

**There's No Meaning in Chocolate: A Narrative  
Study of Women's Journeys Beyond the  
Disruption of Depression**

**Jan Wilson**

**A thesis submitted to  
Auckland University of Technology  
in fulfilment of the requirements for the degree of  
Doctor of Philosophy (PhD)**

**2007**

**Faculty of Health and Environmental Science**

**Primary Supervisor: Lynne Giddings**

# TABLE OF CONTENTS

<b>TABLE OF CONTENTS</b>	<b>ii</b>
<b>TABLE OF FIGURES</b>	<b>viii</b>
<b>TABLE OF APPENDICES</b>	<b>ix</b>
<b>ATTESTATION OF AUTHORSHIP</b>	<b>x</b>
<b>ACKNOWLEDGEMENTS</b>	<b>xi</b>
<b>ABSTRACT</b>	<b>xiii</b>
<b>PREFACE</b>	<b>1</b>
<b>The structure of this thesis</b>	<b>3</b>
The Beginning	3
The Middle	4
The End	4
<b>THE BEGINNING</b>	<b>6</b>
<b>CHAPTER ONE: THE ‘QUIRKY’ IDEA OF THE SELF</b>	<b>7</b>
Arthur Frank and ‘narrative habitus’	9
Māori and notions of the ‘self’	10
Humanist essentialist stories of the self	13
The essential self and bio-medical intervention	15
The essential self and psychological intervention	16
Feminist stories of the self	17
Social-constructionist stories of the self	19
Narrative stories of the self	21
Integrating the stories of self	23
“Beyond constructionism”: Edward Sampson	23
An integrated approach? Jane Ussher	24
Conclusion	26
<b>CHAPTER TWO: SOME PIECES OF THE JIGSAW</b>	<b>28</b>
What does the word ‘depression’ signify?	29
Professional understandings of depression	29
‘Lay’ understandings of ‘depression’	31
Use of the term ‘depression’ in this thesis	33

<b>Women and depression</b>	<b>34</b>
How many women's lives are disrupted by depression?	34
Why do women get depressed?	36
Protective factors	48
<b>Conclusion</b>	<b>51</b>
 <b>CHAPTER THREE: COPING AND RECOVERING</b>	 <b>52</b>
<b>Understanding recovery</b>	<b>53</b>
What does recovery mean?	53
How many women recover from 'depression'?	53
Biomedical paths to recovery	54
Psychological therapies as pathways to recovery	56
Combinations of professional treatments	58
Pathways outside the mainstream	59
Help-seeking and barriers to receiving help	64
Changes in women's lives	68
Women's recovery stories	70
 <b>Need for further research and the place of this project</b>	 <b>73</b>
 <b>CHAPTER FOUR: WE ARE THE STORIES WE TELL</b>	 <b>74</b>
<b>Narrative research overview</b>	<b>74</b>
<b>Narrative Analysis</b>	<b>77</b>
A beginning, a middle and an end	78
Holistic analysis with graphs	79
Arthur Frank's narrative typology	80
Use of poetic form in transcription	81
Strategies in storytelling	82
Characters, themes and plots	83
 <b>Conclusion</b>	 <b>83</b>
 <b>CHAPTER FIVE: A FASCINATING PROCESS</b>	 <b>84</b>
<b>Participants</b>	<b>84</b>
Recruitment	84
Participant Selection	85
Participant Characteristics	88
 <b>Data Collection</b>	 <b>89</b>
Individual Interviews	89
Focus Groups	93
Participants as 'experts'	95
Redressing power imbalance	96
Developing ideas collaboratively and supporting one another	96
Recording and Organising of Data	97
 <b>Analysis</b>	 <b>98</b>
Jolly Good Reasons	100
A disrupted life	100
Seeds of resilience	101
Crawling out is so hard	101
Getting the formula right	102
Poetic transcription	103

<b>Ethical Issues</b>	<b>103</b>
Ongoing negotiation	104
Reflective Critique	106
Te Tiriti o Waitangi	108
<b>Rigour</b>	<b>109</b>
<b>Conclusion</b>	<b>110</b>
<b>THE MIDDLE</b>	<b>111</b>
<b>PREAMBLE TO THE FINDINGS CHAPTERS</b>	<b>112</b>
<b>CHAPTER SIX: DISRUPTED LIVES</b>	<b>113</b>
<b>Structure of this chapter</b>	<b>115</b>
<b>‘Chaos’ stories</b>	<b>116</b>
And then, and then, and then -	116
No future worth anticipating	117
The bottomless depths	122
The chaos of a life disrupted by depression	123
<b>Bodily Experiences</b>	<b>123</b>
Curled up in a Foetal Position	124
Living life at a different pace and in a changing body	125
Disturbed Sleep	126
Physical illness	126
<b>The Role of Other People</b>	<b>127</b>
Profound aloneness: “I don’t want to see anybody”	128
The reactions of others	132
<b>Landscapes of Consciousness</b>	<b>134</b>
Distorted thoughts?	135
<b>Other Mental Health Issues</b>	<b>136</b>
<b>Conclusion</b>	<b>136</b>
<b>CHAPTER SEVEN: JOLLY GOOD REASONS</b>	<b>138</b>
<b>I Just Only Remember it Being There</b>	<b>141</b>
I have always been a depressive	141
Bio-chemical, genetic or familial origins	141
‘Cultural’ Invitations to Depression	142
<b>Beginnings in Childhood</b>	<b>144</b>
Childhood Abuse and Violence	144
Grief and Loss	145
<b>Beginning Stories Centred in Adult Life</b>	<b>147</b>
Abuse and Violence	147
Traumatic Experiences including Grief and Loss	148
Interpersonal trauma	150
Break up of Intimate Relationships	151
Difficulties in relationships, or absence of relationship	153



The Complex Issues Associated with Becoming a Mother	157
Mental Health Problems in Addition to Depression	159
Stress	162
<b>Lifelong Issues</b>	<b>164</b>
Physical Health	164
Poor Self-Esteem	167
A Sense of Being ‘Other’	167
Awareness of the Depressing State of the World	168
<b>Conclusion</b>	<b>169</b>
 <b>CHAPTER EIGHT: THE SEEDS OF RESILIENCE</b>	 <b>171</b>
<b>Positive Beginnings – Foundations for Resilience?</b>	<b>172</b>
Developing Coping Mechanisms	173
People and resilience	174
Pets as a foundation for resilience	176
Spirituality and meaning-making as resilience and foundations for recovery	177
Intellectual and Creative Activity	178
Ways of Being	180
<b>Conclusion</b>	<b>181</b>
 <b>CHAPTER NINE: CRAWLING OUT OF IT IS SO HARD</b>	 <b>182</b>
Structure of the Chapter	184
 “I just sort of lived with it”	 <b>187</b>
<b>False Starts</b>	<b>189</b>
Medical	189
Psychological	192
Other	196
<b>Beginning to crawl out</b>	<b>198</b>
Medical	198
Psychological	200
Other	205
<b>Initiation of Responses</b>	<b>218</b>
 <b>CHAPTER TEN: “GETTING THE FORMULA RIGHT”</b>	 <b>222</b>
<b>Group One: Bounded periods of disruption</b>	<b>224</b>
Charlotte – Re-discovering a ‘family group’	225
Christine: support from a “wonderful” psychiatrist and a “neat” husband	226
Katy: “My God I’m going to live my life. I’m not going to sit here rusting away!”	227
Kay: You need many avenues, but “other women” were the key.	229
Hannah: “All that I have walked is for a reason, and to benefit mankind.”	230
Jane: No longer bitter, but a better person with the support of friends, a ‘separation’ group and many, many books.	231
Fiona: Re-inventing herself as solo parent, and motor-cycling woman	233
Isobel: “Hey! I’m me, and I really like me!”	234
 <b>Group Two: Longer periods of disruption, with different degrees of seriousness</b>	 <b>235</b>
Linda: “if a person presents with some sort of depressive illness, there’s a reason”	236
Marge: “...it had to do with work – I need to let my mind wander and potter...”	237

Kate: Learning to live a life full of colour.	238
Chloe – finding the wise woman, the good mother and the nurturer in herself.	240
Anne – Emerging from the dark	241
<b>Group Three: Depression as a constant presence in life.</b>	<b>243</b>
Karen: “Self-knowledge has been such an important key”.	243
Elizabeth: Discovering really deep down a sense of soul and spirit	245
Ruth: “depression is part of being human... its getting the formula right at any given time, and trusting it”	246
Hine: “the antidote to depression is hope and dreams”	247
Naomi: “I choose life and not death”	248
<b>Conclusions</b>	<b>250</b>
<b>THE END</b>	<b>252</b>
<b>CHAPTER ELEVEN: THERE’S NO MEANING IN CHOCOLATE</b>	<b>253</b>
<b>Introduction</b>	<b>253</b>
<b>Many of the women experienced depression and recovery as gendered</b>	<b>254</b>
Historically situated gender issues	255
Entitlement	256
Feedback from the group	257
<b>Chocolate solutions and the creating/re-creating of meaningful lives</b>	<b>257</b>
‘Chocolate Solutions’	258
Creating/re-creating meaningful lives	259
The women’s meaning-making narratives as a basis for different recovery journeys.	260
<b>‘Symmetrical’ nature of journeys into and beyond the worst disruption</b>	<b>261</b>
Lives severely disrupted, but for a relatively brief time	261
Long and complex journeys into and then beyond the worst disruption(s) of depression	263
Group feedback	264
<b>The holistic experience of living with and without depression</b>	<b>266</b>
<b>Agency, resistance and ‘narrative habitus’</b>	<b>267</b>
‘Happenstance’	268
Intervention of empathetic professional, friend or family member	268
Reaction to a totally unacceptable option	269
Slowly growing awareness of possibilities	269
<b>Conclusions</b>	<b>270</b>
<b>CHAPTER TWELVE: SO WHAT? A POSTSCRIPT</b>	<b>272</b>
<b>My journey as researcher and author</b>	<b>272</b>
<b>The Wishes of Eighteen Women</b>	<b>272</b>
<b>The Wider Landscape</b>	<b>273</b>
<b>Final Words from Kate</b>	<b>273</b>
<b>REFERENCES</b>	<b>275</b>

<b>GLOSSARY OF MĀORI TERMS</b>	<b>291</b>
<b>APPENDICES</b>	<b>292</b>

## TABLE OF FIGURES

<b>Figure One:</b> Representation of developmental structure	<b>79</b>
<b>Figure Two:</b> Representation of researcher's journal page	<b>99</b>
<b>Figure Three:</b> Analytic grid for 'Crawling out is so hard'	<b>102</b>
<b>Figure Four:</b> Analytic grid for 'Crawling out is so hard'	<b>184</b>
<b>Figure Five:</b> Historical context of depression. Group One	<b>224</b>
<b>Figure Six:</b> Historical context of depression. Group Two	<b>235</b>
<b>Figure Seven:</b> Historical context of depression. Group Three	<b>243</b>
<b>Figure Eight:</b> Jane's journey	<b>262</b>
<b>Figure Nine:</b> Katy's journey	<b>262</b>
<b>Figure Ten:</b> Naomi's journey	<b>263</b>
<b>Figure Eleven:</b> Elizabeth's journey	<b>264</b>
<b>Figure Twelve:</b> Linda's journey	<b>265</b>

## APPENDICES

<b>A</b>	(i) Poster Version One	<b>294</b>
	(ii) Poster Version Two	<b>295</b>
<b>B</b>	NZAC Advertisement	<b>296</b>
<b>C</b>	Leaflet for advertising in Gym	<b>298</b>
<b>D</b>	Pre-selection Brief Interview – Outline	<b>301</b>
<b>E</b>	Participant Information Sheet	<b>303</b>
<b>F</b>	Introductions to the Women	<b>307</b>
<b>G</b>	Interview Outline	<b>321</b>
<b>H</b>	Individual Interview Consent Form	<b>323</b>
<b>I</b>	Group Participants Consent Form	<b>326</b>
<b>J</b>	Notes for Participants in Group Discussions	<b>329</b>
<b>K</b>	Women’s Feedback for Group Discussion	<b>334</b>
<b>L</b>	Agenda for Group Meeting One	<b>336</b>
<b>M</b>	Explanation of Memory Work	<b>339</b>
<b>N</b>	Graphical representation of depression journey	<b>342</b>
<b>O</b>	Example of N-Vivo Codes	<b>344</b>
<b>P</b>	Example of Mind Map for ‘A Disrupted Life’	<b>352</b>
<b>Q</b>	Mind Map : Out of Chaos	<b>354</b>
<b>R</b>	Ethics Approval from University of Waikato	<b>356</b>
<b>S</b>	Ethics Approval from Auckland University of Technology	<b>358</b>
<b>T</b>	DSM IV Diagnostic Criteria for Major Depressive Disorder	<b>360</b>

## **ATTESTATION OF AUTHORSHIP**

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the qualification of any other degree or diploma of a university or other institution of higher learning, except where due acknowledgement is made in the acknowledgements.

Signed: \_\_\_\_\_

Dated: \_\_\_\_\_

## ACKNOWLEDGEMENTS

First I would like to thank the eighteen women who shared their stories so willingly in the hope that they could help other women whose lives have been disrupted by depression. I have been humbled by their stories of determination, persistence and courage as they have often stood their ground to refuse unhelpful treatment and continue to seek things that worked for them. The five women who were able to meet together with me added a special kind of collegial wisdom, which enabled me to better read and understand the narratives. Thank you all.

The study was inspired by women I have met in my life both personally and professionally; women who have struggled to overcome depression and who have often found ‘non-professional’ things which have been really helpful. Thank you.

Thank you to my primary supervisor, Associate Professor Lynne Giddings. You have given so much over so long – I could never have completed this work without you. You have been my mentor, my supporter and my friend. I thank you for your wisdom, your wonderful knowledge, your feminist strength, your kindness and your faith that this thesis would be completed. I also want to thank Dr Hilary Lapsley who supervised me at the start of the project. Your work inspired me, and I thank you for extending your support well beyond your commitment. In the last few months I have also had precious support and encouragement from Associate Professor Liz Smythe.

Thank you to all my colleagues who have uncomplainingly supported me as I have worked on this project over many years. The team at Health, Counselling and Wellbeing have been amazing, especially my counselling colleagues. In my more academic work I thank Dr Marion Jones for her support and encouragement and her faith in me as a writer and researcher.

To my PhD buddies, Kate, Tony and Gil; it has been great to have you all walking this journey with me. To ‘Henry’, my counselling support group who have met monthly for more than ten years offering every possible kind of encouragement; thank you Barbara, Mary, Gabrielle, Richard and Tony.

A special thanks to my Mum, who died in the year that I started this project. She had managed the stresses in her own life by taking up bridge, spinning and weaving and patchwork! She always believed in women’s ability to be experts on their own lives, and taught me to believe this too. My Dad has quietly stayed in the background whilst I

completed this thesis, but always knew I could do it. He too believes in women's wisdom!

Thank you to all my immediate family, Xavier and Jo, Pip and Kennedy and little Max, and Andrea and Simon. I will now have much more time to enjoy you all, but in these last years you have kept me focussed, helped through solving computer problems, giving cuddles and hugs and cups of tea. Thank you for understanding when I couldn't be with you because of "IT".

To Ruthie, my partner, who has never known me without a PhD being there too. Thank you for your patience, love and support, and for waiting for the evenings and weekends that will now be available.

My thanks to Dr Alison Towns for her careful reading and critique in the last few weeks before completion.

This thesis reports on research involving human participants. Therefore ethical approval was sought from the Auckland University of Technology Ethics Committee and granted on the 5<sup>th</sup> June, 2000 (Reference No. 00 / 10), and from the University of Waikato Ethics Committee who granted approval on 6<sup>th</sup> March, 2000.



# ABSTRACT

Professional treatment, mainly medical and psychological, dominates research and clinical practice concerning women and their recovery from depression. This thesis challenges the assumption that women cannot be ‘experts’ actively involved in their own recovery. This study explored the narratives of eighteen women in Aotearoa New Zealand whose lives had been seriously disrupted by depression. They had found ways other than, or in addition to, professional solutions that helped them to live undisrupted meaningful lives.

The research used a narrative inquiry approach informed by authors from across the social sciences including Arthur Frank, Jerome Bruner and Rivka Tuval-Mashiach. The underpinning social constructionist understanding of depression is informed by the work of Jane Ussher and Janet Stoppard. The women whose individual narratives provide the core data for the study ranged in age from 32 to 70 years at the time they told their stories. Their lives had been disrupted by depression at different times during the last 50 years of the twentieth century. Five of the women met as a group with the researcher as the analysis began, and their ideas informed significant aspects of the conclusions.

The women had all experienced major depressive disorder, although this was not always formally diagnosed. Their recovery had involved a range of responses from outside the professional mainstream including physical, mental, social and spiritual aspects. Each woman had sought and found a ‘formula’ that was ‘right’ for her. The narratives showed all the women talked of their experience with depression and recovery in an holistic and contextualised way. They all talked about ‘chocolate’ solutions which provided symptom relief, and ‘deeper’ and often more complex sets of solutions which enabled them to discover or re-discover meaningful ways to live. Meaning-making often involved growing spiritual or transpersonal awareness in the broadest sense. A surprising finding was that the patterns of recovery were not related to the severity of the depression at the worst time. Rather, it emerged that the ways the women talked about their recovery journeys mirrored their stories of the ‘jolly good reasons’ why they were depressed; the more complex and lengthy the story leading up to the worst times, the more complex the formulae required for recovery.

The implications of the research for clinical practice and for policy makers are that depression and recovery need to be seen as gendered, contextualised, and holistic.

Women need opportunities to discover and take advantage of a range of ‘things’ so that they can find their own ‘right formula’ for recovery. This formula may involve professional treatment including anti-depressant medication and psychological therapy, but it is likely to involve many other things as well. This study challenges the notion that recovery needs to be guided by a professional expert, and creates hope for women being able to learn from each other’s experiences.

# Preface

The disagreement between women and experts about the best treatment for depression is not a new phenomenon. In 1892 Charlotte Perkins Gilman, an American, wrote a short novel about an intelligent, educated woman whose life was disrupted by depression. Gilman included this passage about the heroine's experience of depression:

And what can one do?  
If a physician of high standing, and one's own husband, assures friends and relatives that there is really nothing the matter with one but temporary nervous depression – a slight hysterical tendency – what is one to do?  
My brother is also a physician, and also of high standing, and he says the same thing. So I take phosphates or phosphites – whichever it is, and tonics, and journeys and air, and exercise, and I am absolutely forbidden to 'work' until I am well again.  
Personally, I disagree with their ideas.  
Personally, I believe that congenial work, with excitement and change, would do me good.  
But what is one to do?  
I did write for a while in spite of them; but it does exhaust me a good deal – having to be so sly about it, or else meet with heavy opposition.

(The Yellow Wallpaper, Perkins Gilman, 1996, p.10)

In New Zealand, more than one hundred years after the publication of *The Yellow Wallpaper*, women told me stories of their own journeys through depression. Like Gilman's heroine, these women had discovered things that would "do them good", and these were not always the ways recommended by physicians and other experts. One of the women, Elizabeth<sup>1</sup> said:

*It's been a conscious decision on my part. I guess growing up through the early seventies and eighties, you know, it was very anti-drug. Got to be another way. And at times, yeah I don't know, whether it might have helped. I'm just trying to think back whether I did actually take any antidepressants at any time. I know that doctors at times did prescribe them.... In fact very recently ....I did a huge dive and I .... sort of in a slightly panicked state I rushed down to my doctor.... and he just looked at me and he wrote out this prescription for Aropax. And I brought it home, I went and got it. And I brought it home, and I thought "This is not what I want! This is not.... this is like." It was like I'd gone this far and to that extreme and then, I thought "No". So, (snaps fingers) "No, that's not it." And I knew it. I knew it. I knew that this was not right. It was like when I look at the sort of circumstances and stuff that I was going through, it was sort of all part of it. But, yeah, I was just interested how easily the doctor went (snap). "Here you are, here's some, this will fix you Elizabeth".*

Charlotte Perkins Gilman and Elizabeth were removed from each other by a century in time, and half a world in location. Both women, however, reveal some distrust of physicians and an awareness that they themselves may know how better to respond to the symptoms often associated with depression. Yet frequently it is difficult or

---

<sup>1</sup> Elizabeth is the pseudonym chosen by the participant whom I am citing. All participants selected a pseudonym to be used in this thesis.

impossible for women to tap into their own wisdom and stand against the advice of powerful experts.

When I started this project, I was in my mid-fifties, and had worked as a counsellor since the late nineteen seventies. Depression has never seriously disrupted my life, but I have lived with a loss of both hope and meaning on a number of occasions. None has lasted more than a few weeks, but I have glimpsed and feared the possibility of entering into this kind of chaos. When I was in my mid-thirties, and living on my own with a young child, I found I had life threatening cancer. My response was to seek the help of experts and to follow their advice. At the same time I knew that I needed something else and became involved with two other people, in similar situations, and together we set up Cancer Call. This became a support and self-help group for people who either had cancer or were very close to a loved one with cancer. I have known for a long time that the experts do not have all the answers and that even with a serious physical illness healing can come from within, from friends, from family, from poetry and exercise and pets and cooking and sharing meals and from walking along the beach in the moonlight and the rain.

In the course of my work as a counsellor I had been privileged to hear inspirational stories of women whose lives had been seriously disrupted by the experience of depression. Many of these women had found their own unique ways of responding constructively to their distress, and often their responses did not fit with the advice, beliefs or recommendations of mental health professionals, including myself. Initially, when they told me about the helpful, meaningful things they had done, many were apologetic, ashamed and secretive. It seemed they felt they had not been following an appropriate treatment plan, and that I, as the ‘expert’<sup>2</sup> professional might disapprove.

My belief is that lay wisdom deserves to be recognised as worthwhile knowledge. Over the years I have passed on many of these ‘non-expert’ solutions to other women when they have been experiencing depression in their lives. This shared wisdom has been useful. Through these many conversations in my professional life, I have developed an interest in listening to, and paying heed to, the wisdom of those experts on themselves. Their particular stories cannot be told because they were shared

---

<sup>2</sup> Throughout this thesis I will use inverted commas to interrupt a routine reading and challenge the reader to unravel the use of a word within any particular context or to challenge taken-for-granted assumptions about a word and its meaning.

in the confidential space of the counselling room. This project is an attempt to give voice to women's wisdom within the ethical structure of a formal research project. The narratives have been told within the historical context of Aotearoa New Zealand at the beginning of the twenty-first century, and I hope that through this project these voices will become available to a wide audience, including mental health professionals, and other women experiencing depression. The opportunity will be given for an audience to attend to some of the marginalised, non-professional discourses of women moving beyond the disruption of depression and creating lives full of meaning. When they are shared, marginalised discourses can acquire a power to disrupt and problematise the dominant taken-for-granted stories.

I have found that many of the women's stories involve tales of resistance. They tell how they have stood against the dominant, professional discourses and technologies of depression and recovery, and managed to invoke their own agency. These ideas of resistance, agency, and dominant and marginalised discourses are drawn from social constructionist, feminist and postmodern thinking. In Aotearoa New Zealand the work of Māori, the first nation people of this land, has also focussed on issues of power and marginalisation. These approaches have influenced my understanding of what it means to be a woman, to be a person and to have a self. They underpin this thesis.

Ideas of the 'self' are troubling. Gergen (1998) has suggested that not only psychologists, but also philosophers, novelists, and historians are "challenged with the problem of rendering in words a sense of recognition, a sense that 'I know and understand the person whereof they speak'" (p.111). Michele Crossley (2000) introduced her book on narrative psychology with a chapter on theories of the self and identity, and in the same way I am going to lead into this thesis with an exploration of some of the ideas related to the self and subjectivity which have informed my thinking, my practice and my research.

### ***The structure of this thesis***

The thesis starts with this preface, and then proceeds like a story with three sections; a beginning, a middle and an end.

### **The Beginning**

In the first chapter of this thesis I consider *The Quirky Idea of the Self*. I will expand on the ideas of Gergen (1998) and Crossley (2000) and discuss further philosophical assumptions that have informed my work. In the two following chapters I review

relevant literature. My selection was based primarily on work relevant to the research topic and to my philosophical approach, and includes a range of significant literature. I have, however, sought out work which was informed by feminist and social constructionist understandings and have included, where possible, research which recognises and values the knowledge of women who have experienced depression. Chapter Two, *Pieces of the Jigsaw*, reviews literature which gives a background to the study. It involves work about depression, its gendered nature and possible causes. In Chapter Three, *Coping and Recovering*, literature is reviewed which focuses on the research topic; women's recovery from depression. In Chapter Four, *We Are the Stories We Tell*, I explore narrative ideas and the narrative inquiry approaches that I have used in this project. Chapter Five, the final one in this section, is called *A Fascinating Process*. In it I describe the methods I used in my research.

### **The Middle**

The second section of the thesis consists of five chapters of findings. Chapter Six, *A Disrupted Life*, is about the worst times of depression. This is followed by Chapter Seven, *Jolly Good Reasons*, where I analyse the parts of the women's stories where they explain how they believe depression came to disrupt their lives. In Chapter Eight, *The Seeds of Resilience*, I present the stories the women told which explained the enduring resources, interests, and strengths that they recognised in themselves. These were elements of resilience and helped the women discover ways to reduce the impact of depression on their lives. These first three findings chapters do not seem to focus directly on recovery, but the stories that are analysed in them emerged as essential and integral parts of the women's narratives of recovery. Chapter Nine, *Crawling Out is So Hard*, tells about the attempts, both professional and non-professional, that the women made to find a way to recover. Some of these were false starts, others led to partial recovery. The final chapter in this section, Chapter Ten, tells about the solutions the women found that worked best for them. This is a chapter about *Getting the Formula Right*.

### **The End**

The third and final section of the thesis consists of two chapters. In Chapter Eleven, *There's no Meaning in Chocolate*, I draw together common themes and patterns and reflect on the findings. This chapter includes ideas from the group of five participants who met with me as I started the analysis. They assisted me by reflecting on some of

the themes and questions that I had discerned from the narratives. In the final chapter, Chapter Twelve, *So What?* I consider implications for further research, for professional practice, and for women experiencing depression.

# THE BEGINNING

The five chapters in this section tell the story of how this project came into being. I explain why I decided to explore the stories of women who have overcome depression without a lot of help from professionals. I tell the story of how the women were chosen, how I collected their narratives and how I found ways to analyse them with respect and integrity.



# Chapter One: The ‘quirky’ idea of the self

*Oh God, thinks Flora, oh God. She is trembling, tears running down her face. Poor baby. Poor baby. Poor me. Something is happening to me, she thinks. The young me disappeared thirty years ago and a week ago when I got Chloe’s note, the Flora that was around then vanished as well. Writing this letter has brought another Flora into being and I don’t know a thing about her.*

*You can say hello, she thinks. The least you can do is say hello. Make her feel welcome. Because she’s not really new is she? She has to be a mixture of both Floras and all the Floras to date, there must have been more than two. “Hello Flora”, she says out loud. “Hello.”*

*“I’m going mad,” she tells the computer.*

Renée (1995). *Does This Make Sense To You?* p.146

In her novel, Renée (1995) shows a woman grappling with the complex, inconsistent and contradictory experience of her identity, her ‘self’. Flora concludes that if she does not experience her self as consistent, coherent and rational then she must be “going mad”. This is an assumption common in Western thinking, and I would dispute it. Notions of the ‘self’ are central to the understanding of depression, and therefore to this thesis, which explores narratives of women whose lives have been seriously disrupted by depression. The ‘elusive’ and ‘quirky’ self is central because the experience of depression is commonly talked about by both professionals and lay people as centred in the ‘self’. The most readily available and widely researched pathways to recovery from depression involve professional solutions such as medication and therapy. This thesis focuses on the narratives of women who have resisted these treatments and discovered ‘alternative’ ways to recover from depression and restore meaning to their lives. The theoretical ideas which underpin the project are necessarily concerned with the self.

In this thesis the ‘self’ is viewed theoretically as socially-constructed, multi-faceted, and contradictory; a ‘subject’ constituted through language, and especially through narrative. Jerome Bruner (2002) wrote “ ‘Self’ is a surprisingly quirky idea – intuitively obvious to common sense yet notoriously evasive to definition by the fastidious philosopher” (p.63). This quotation is the source of the title for this chapter, and I will explore a range of understandings of the self which I have found useful. Jane Flax (1993) devoted a whole book to ‘disputed subjects’, with one chapter addressing the debate about the modern subject, and including an introductory section entitled “An Elusive Subject”. She wrote:

Subjectivity is a central concept in post-seventeenth-century Western thought. Stories about subjectivity concern a crucial figure in the modern West – the subject. This subject must do an enormous amount of work. It plays essential roles in philosophy and politics. In philosophy the subject grounds, represents, or generates knowledge and our accounts of it. In politics it grounds the possibility of freedom – freedom from determination and domination, freedom to be self-determining and sovereign.

(Flax, 1993, p.92)

The understanding of the self or the subject is critical to many theories of depression. Dana Crowley Jack (1999), for example, has studied women and depression for many years and developed the idea of depression arising from women's "silencing the self" (p.10) as a significant part of her complex theorising. The term is, however, used in many different ways. Even within social constructionist research on depression there are different theoretical standpoints. In this chapter I will present some of the debates concerning the self and subjectivity, which are relevant to my research, including my choice of topic and of methodology. I will argue for the legitimacy of a position within social constructionist thinking which allows for both a feminist and a critical understanding and which makes sense of embodied lives as they are told into being through narrative. This argued position is also inclusive of a 'spiritual' or 'transpersonal' dimension.

Naming calls things into existence. A century ago most of the social sciences, including psychology did not exist, and had not been named. In the time since their naming their influence has become significant in the Western world, particularly in the ways that we think of ourselves and our relationships. When I write about how we understand our 'subjectivity' I am calling on a very recent form of languaging; one which at this point in history will have meaning for a relatively small group of academics and scholars. Although I will use such specialist language at times, to convey ideas that are important to my thesis, I will try to make my writing accessible to a range of academics, clinicians and interested lay people. I will also be writing from the standpoint of a clinical practitioner. At this point in time my clinical practice is informed by feminist, narrative and social constructionist ideas.

Arthur Frank's narrative thinking informs much of this thesis, especially his ideas about 'narrative habitus'; a notion that I refer to often in this chapter. As I will explain, it is an idea which offers insights into the dialogical distance which often exists between women living with depression and the professionals who try to assist their

recovery. Frank's ideas of 'narrative habitus' also helps me to explain the choices I have made about the stories of 'self' I discuss in the rest of the chapter. There are reasons why these particular stories have 'called out to me' and asked to be 'taken seriously' in my search for ideas that are useful for this particular research project.

### ***Arthur Frank and 'narrative habitus'***

Arthur Frank (Frank, 1992, 1995, 2002a, 2002b; Frank & Jones, 2003) is a sociologist with an interest in chronic illness and in narrative theory. I will discuss his theory in greater detail later in this chapter, but here I focus on his 'narrative habitus' construct. I recognised its relevance to my project when I heard Frank talk at a two day workshop here in Aotearoa New Zealand. Frank (2002a) has an interest in relationships and in the development of the self through dialogue. He has focussed his research on relationships between patients and clinicians. Rather than asking how these two groups of people can at times act so badly towards each other, he argued that a different question needed to be asked. "What stories have these people become caught up in?" (p.16). The notion of people being 'caught up in' some stories, but not in others, is at the centre of his concept of 'narrative habitus'.

Pierre Bourdieu's (1998) notion of 'habitus' is acknowledged by Frank (2002a). Bourdieu (1998) suggested that most of the time people are "caught up in a game", a game which they believe is "worth the effort" and which involves "stakes" which they consider to be "worth pursuing" (p.77). Whilst the person caught up in the game takes the stakes seriously, others who are not caught up in that particular game may see these stakes as "illusory".

Being caught up in particular games is only one aspect of 'habitus' that Frank (2002a) sees as comprising:

the embodied habits, tastes, and dispositions that are acquired through growing up in families and neighbourhoods .... Having certain friends who value this and deprecate that, going (or not) to schools and churches, having jobs, and living in local worlds of practice and preference (p.17).

He suggests that affinities between people are often based on 'shared habitus', which is "socially constructed all the way down" (p.17). One feature of habitus is that although it is constantly acted upon, it is not "thought of". When a person acts within their habitus, it "feels right". This idea conveys a particular notion of self. Frank suggested that being oneself is both embodied and moral. "To pursue the stakes is to be the person

one feels right being: actions in pursuit of these stakes feel right, and seeing oneself in such a moral image, one looks right to oneself” (Frank, 2002a, p.18).

Frank asserted (2002a, p.19) that people have a lack of choice in the games they become caught up in, and “to be caught up in one game is to be unable to be caught up in others” (Frank, 2002a). He argued that dialogue can assist people to take notice of each others’ games. People can “take up games to which they are not predisposed by their habitus” (p.20). Dialogue is possible because people are caught up in different stories. Listening to another’s stories then draws on a person’s capacity to “share what makes someone’s story worth telling and thus worth hearing” (p.21).

These ideas offer one way of understanding the dialogical distance which can exist between women experiencing depression and the professional experts who are trying to ‘treat’ them. They also suggest ways that this gap might be reduced. From another standpoint they offer a framework that I can refer to when acknowledging the particular ‘narrative habitus’ that I am caught up in as I work on the project presented in this thesis.

Much of ‘The Beginning’ of this thesis involves my critical reflection on a variety of stories which I consider worth hearing. They are ‘stories’ from professional practitioners, from researchers, from theorists and from women, all of which I consider relevant to my research project. Reflexive critical analysis is a key aspect of many feminist psychologies, and can “potentiate the emergence and actualization of formally marginalized discourses and practices and open up local possibilities for resistance to dominant discourses” (Hawes, 1998, p.94).

Some of the most significant stories about self that I have been caught up in during the past thirty years come from humanism, feminism and from the first nation people of Aotearoa New Zealand, Māori. In the past ten years social constructionist and narrative stories have also ‘called out to me’ and I have discovered that for me they deserve to be taken seriously. All these stories about ‘selves’ have become part of my current narrative habitus. I will now discuss the ways that I discovered them and became able to engage with parts of all of them so that they have been able to inform my thesis.

### ***Māori and notions of the ‘self’***

I am a Pākehā New Zealander. Some of my ancestors have lived in this country since the early eighteenth century. I am a member of the dominant European culture. For

fifteen years during the sixties and seventies my ideas developed in another British colony, Australia, and then in the colonising country of the United Kingdom. The primary cultural context in which my ideas have been formed, however, has been that of Aotearoa New Zealand. This is a place where, particularly during the past twenty-five years, the stories of Māori have become increasingly available to me, and have influenced my thinking.

During my years working as a counsellor I have had the good fortune to have worked in professional and clinical teams alongside Māori clinicians. The Māori women whom I want to personally acknowledge are Pat Ford, Jenny Te Paa, Aorangi Logan, Monique Knight, Maria Reynolds, Jude McCarthy and most recently Lynne Cartwright. These women have each, for periods of time, been for me a living presence of an holistic philosophy which accepts the spiritual as a part of everything we do. I also want to acknowledge the value of my contact with ‘Hine’ the woman who volunteered to participate in my study and who identifies as Māori.

Stories of indigenous, holistic understandings of the self and associated theories are not only available through personal relationships, but also through published writings of eminent Māori scholars. One of the most prominent, Mason Durie, well-known psychiatrist and academic, has published influential work about Māori health, especially mental health and social policy (Durie, 1998b, 2001, 2003). His work is referred to by both mental health researchers and clinicians. Durie talked of a relational approach to therapy which he has named “paiheretia”<sup>3</sup> (2003, pp.47-58). He commented on Māori dissatisfaction with mental health approaches which focus on “symptom clusters, syndromes or isolated behaviour patterns” (p.48), and contrasted this with a Māori approach. He offered depression as an example:

Depression and anxiety, for instance, may not be viewed as isolated areas of dysfunction but as indicators that the balance between emotions, social relationships, spirituality and the body have become distorted. That perspective underlies a relational approach to health and human understanding which is not easily accommodated within a disease or behavioural orientation. (p.48)

A constant message in Durie’s writings is the difficulty of finding a “ready explanation” for poor mental health, and he acknowledges a necessary unknowingness at times. When he focussed on the development of secure identity he again contrasted

---

<sup>3</sup> A glossary of Māori words used in this thesis is included before the Appendices on page 291

an indigenous approach such as *paiheretia* with most Western “insight-promoting” systems. The latter “presume that insight comes by probing attitudes, memories, thoughts and ideas” (Durie, 2003, p.49) whereas Durie’s approach “assumes that identity, self-knowledge and idiosyncratic behavioural patterns are a reflection of a complex interaction between the individual and the wider environment” (p.49).

The ‘wider environment’ Durie refers to is political as well as relational and physical. Durie (2001) stated that:

... psychological well-being is related to personal encounters, developmental experiences, societal values and equity, stress, genetics, culture, standards of living, physical health, and political influence. In short, the foundations for mental health are to be found as much outside the mind and the body as within (p.35).

He earlier explained, albeit using different terminology, the serious implications of professionals working from a story which is different from the narrative habitus of Māori (Durie, 1998a). Durie expressed concern at the high rate of diagnosed mental health problems amongst Māori, especially Māori youth, and noted that approaches which make sense in cultural terms have been largely ignored. Māori take an holistic approach, embracing four significant aspects of life (Durie, 2001); *Taha Tinana* (physical wellbeing), *Taha Hinengaro* (mental wellbeing), *Taha Whanau* (social wellbeing) and *Taha Wairua* (spiritual wellbeing). Durie was concerned that the Western view has taken precedence and determined both recommended treatment and funding options. The valuing of medical models has “conjured up an expectation that ‘treatment’ is possible and that a DSM-IV diagnosis will somehow lead to a resolution” (Durie, 1998a). Durie is sceptical that such approaches will lead to any reduction in Māori mental health problems.

Linda Tuhiwai Smith (1999), also a prominent Māori academic with a particular interest in education and research, drew attention to the implications for Māori of living in a society dominated by belief systems about the self and about society where there are cultural definitions which “do not connect with either our oral traditions or our lived reality” (p.170). A few years earlier, Tamati Cairns (1996) summarised the Māori holistic view of the self embedded in the culture when he addressed a hui (Māori gathering) on strategic directions for Māori health research. He told the hui that they needed to start by looking at themselves, and that this meant “know yourself, your whanau, hapu, iwi, your tikanga, your reo, the customary concepts and other aspects that make you special” (p.31). For Māori the self is inextricably linked with the

immediate family (whanau) and the more extended parts of the family (hapu and iwi) as well as with traditional customs and beliefs (tikanga) and language (reo). This is very different from either a Western individualised view of the self or even a relational self in modernist Western psychology. For many Māori the links are beyond other living selves to a wider sphere including the tupuna (ancestors), the land, the language and all manner of taonga (treasures).

At the same time that I was developing a growing awareness of Māori understandings of self, I was involved in both formal and informal learning about a very individualised and often de-contextualised self. In the late 1970s I was training as a counsellor. The underpinning philosophy of the course was based on the philosophy and practice of Carl Rogers. I was an involved and committed member of a ‘psy’ society made up of “free, autonomous selves” (Rose, 1996, p.1). I was taking seriously the stories of a Western, essentialist self.

### ***Humanist essentialist stories of the self***

My early training as a counsellor was firmly grounded in humanist ideas, and there are times when these essentialist ideas of the self still ‘feel right’ to me. There is an optimism about Carl Rogers’ (1961) view that if each individual could act with honesty and ‘realness’, value their self, their feelings and the experience of the moment, then we would live in a world of mutual respect. The autonomous self, free of façade and developed as a mature, integrated self was the goal of many humanist therapists (Rose, 1989, p.246). There were, however, significant aspects of being which humanism minimised or ignored. These include power, context and contradiction.

Davies (1991) took power and context into account, challenging the humanist version of the ‘self’ as having a stable, continuous, unified, rational, coherent core identity. This essentialist view of the self as a unitary, separate and unique whole, encourages a reductionist search for unitary patterns within human kind. It also supports both ‘othering’ and ‘saming’ where one person can be classified in a binary fashion as being either the same, or different from another person (Kitzinger & Wilkinson, 1996). Such understanding supports the construction and reification of such classification systems as the DSM (American Psychiatric Association, 2000).

The idea of an essentialist self can result in an acceptance that some people may have a ‘depressive’ personality, and others not, or at the very least that they may be suffering from ‘clinical depression’. The DSM classification system as a reflection of

‘truth’ is doubted by many (e.g. Read, 2005; Read, Mosher, & Bentall, 2004; Ussher, 1997), and I would support a view of it as a socially-constructed classification system. Such systems enable separation of the ‘mad’ from the ‘sane’ and in so doing differentially value people in these two categories. Decisions about such ‘binary’, either/or labelling is almost always made by professionally trained ‘experts’. Power relations, where the experts have power through formally acquired knowledge, are central to such practices. Classification systems may also result in the belief that a woman can have the identity of a depressed person, rather than depression being an experience that can interrupt her life in a temporary way, and exist alongside many other experiences. Stoppard (2000, p.185) challenges the idea of women “having depression” which situates a problem within an individual, and implies that depression is a ‘health’ problem which would need to be treated by an expert, especially a medical expert. Busfield (1996) has also argued that essentialist psychology can tend to take “little cognisance of differences in women’s experiences, such as those of age, class, ethnicity, time or place” (p.175). It is frequently an approach that leads to either/or decisions, rather than a more inclusive but complex both/and.

Another reason for introducing and problematising humanist ideas of the essentialist, interior self is that such notions underpin much of the biomedical research and practice about mental health, including work about women and depression (Stoppard, 1997, 1998). The humanist view tends to focus on the individual in a relatively neutral environment. One of the implications of such a view for research about women’s experience of depression is that it is likely to de-contextualise the experience, ignoring a range of significant factors such as trauma, abuse, and disempowering practices and relationships<sup>4</sup>. The focus remains on the intra-personal often at the expense of the inter-personal, and of influences from society at large. From a humanist, essentialist standpoint, recovery from ‘depression’ would focus on personal change, perhaps through Rogerian counselling that focuses on the ability of the individual woman to change her life through a process of guided self-reflection and awareness. Bio-medical and psychological interventions are consistent with this ‘person-centred’ understanding of the self. Whilst they may alleviate distress for the individual they can also encourage feelings of self-blame, and allow the women to continue to live, unaware in an unhealthy and unhelpful social and political context.

---

<sup>4</sup> These contextual issues and their relationship to depression will be reviewed in Chapter Two.



## **The essential self and bio-medical intervention**

When depression is understood as located within the 'self' then it makes sense to use a cure which also works within the individual. When this understanding is accompanied by a belief that biological factors play a significant role in the development of depression then medical solutions such as antidepressant medication seem an obvious option. Stoppard (2000) challenges the pathological overtones of such biological discourses of women's depression. This discourse is one of the "resources drawn on by women in their attempts to understand and make sense of their depressive experiences" (p.90). The power/knowledge of the scientific and medical experts and consequently of their accounts contributes to this medical/scientific discourse of depression. This mainstream approach to understanding depression then becomes readily available to women when they try to explain their distress, and find ways to 'treat' their symptoms. They are encouraged to take the advice of professionals and to doubt their own knowledge.

The professional, scientific, 'expert' approach can easily result in women who are experiencing symptoms of depression becoming constructed as 'depressed women' in need of the treatment offered by the experts from the currently powerful and dominant discourse. Their knowledge is treated as 'other' to the powerful knowledge of doctors and therapists. The dominant discourse of the late nineteenth century is present in the quotation from Frances Gilman which introduced the Preface to this thesis. At that time the experts prescribed bed rest and severe reduction of any intellectual or social stimulation for women who experienced depression. A century or more later they are more likely to advocate pharmacological solutions. At either time the woman is constructed as not knowing what is best for herself.

The bio-medical view of depression can result in totalizing 'truth' statements by 'experts' such as the following: "Depression is a disabling illness, often chronic in nature and characterised by persistent low mood, negative cognitions ... and neurovegetative signs" (Walsh, 1998, p.166). The treatment consequence of such a view is usually medication (Wilson, 1997), and at times such radical cures as electroconvulsive therapy (ECT). Prozac has been a common drug therapy treatment for depression since the late 1980s (Hewitt, Fraser, & Berger, 2000, p.163). Hewitt et al. (2000) wrote of their concern that accepting with little question the success of Prozac and similar psychoactive drugs as a legitimate way of managing mood, has major implications for any "theory of the self" (p.175). Kramer has written an

accessible critique of the impact of Prozac (Kramer, 1994) and comments on how such medication has allowed “a person to experience, on a stable and continuous basis, the feelings of someone with a different temperament and history” (p.195). The common treatment of depression with medication has significant implications for the experience of ‘self’, and also allows the circumstances of the woman’s life to be ignored.

Psychological treatments of depression, based on an essentialist or a humanist model, also often limit a focus on context although they may value the person and their potential.

### **The essential self and psychological intervention**

Carl Rogers was at the centre of the humanist movement within clinical practice. From his point of view human emotions had primacy in driving thought and behaviour (Mahoney, 1991). For humanist therapists the self is engaged in a process of self-actualisation, and change occurs through a process of peeling back layers and masks to enable the individual to ‘become’ their real, essential self. Rogers (1961) stated this fundamental principle as follows: “It seems to me that at the bottom each person is asking, “Who am I, really? How can I get in touch with this real self, underlying all my surface behaviour? How can I become myself?” (p.108). Rogers (1951) acknowledged the environment, but in a person-centred way. One of his nineteen basic propositions about personality and behaviour was that “every individual exists in a continually changing world of experience of which he is the centre” (p.481).

A humanist view of the self and its essence enables the individual woman and her experience to be valued, but it also offers the professional a powerful and dominant position of holding expert knowledge which is privileged ahead of any lay knowledge. It has been suggested (Ceci, 2003) that the humanist, essentialist view supports practitioners in their ability to “gather knowledge” and then “more or less straightforwardly, act on or with this knowledge” (p.62). This simplicity is tempting, especially to the clinical practitioner. However, there is a need, not only for awareness of the context within which depression enters a woman’s life, but also for an understanding which takes account of power and gender. In contrast to humanism, poststructuralism and critical feminism enable an understanding of hegemonic power to enter into the analysis of women’s experiences of depression and thus address power issues especially as they relate to gender.

## ***Feminist stories of the self***

Many feminist and post-structuralist researchers have drawn attention to the shortcomings of a person-centred approach to the understanding of mental health issues. Linda McMullen (2003) for example brings to her work her understanding as a “white, Western, female, clinical academic” along with an interest in “culture and gender” (p.20). She reviewed contemporary Western society understandings of the “distress we label “depression”” and noted the extent to which this is viewed as involving “characteristics of my person, ... personal flaws or failings, ... my deficiencies as a person” (p.17). Her research involved an analysis of “how the deficient or flawed self is constructed in the language of ten women in psychotherapy” (p.20). Each woman had “received a diagnosis of some form of depression”.

Becky Francis (The London Feminist Salon Collective, 2004) questioned the humanist, person-centred, concept of self as “too fixed and simplistic an account of human selfhood and interaction”, whilst commending post-structuralist approaches for their ability to help women “recognise and explore the nuances of power” (p.27). I have a concern, however, that in abandoning the idea of an essential self we might be left with no notion of a coherent self (A. Jones, 1997). The experience of living as a coherent person in “day-to-day” life is important (The London Feminist Salon Collective, 2004, p. 29), and one which acknowledges the pain of individual women. The rejection of ‘grand’ and ‘totalising’ narratives may still allow space for the study of “individual subjectivities” and their suffering (J. M. Anderson, 2004, p.238). These ideas are explored further in Chapter Four where I discuss the reasons I selected a narrative approach to my research.

Another aspect of the exploration of power that is important in this thesis is that suggested by Pomeroy, Holleran and Kiam (2004). They argue that postmodern feminism in its embrace of diversity can focus on female strengths rather than subjugation. The efforts of Pomeroy and her colleagues to use a postmodern feminist framework to inform their work with women in prisons is of special interest to me because of their attempt to link the theoretical with clinical practice. They also seek a way to value social change and social justice, a project of importance in mental health areas of practice. Humanist views, as already discussed, have supported a focus on the medicalisation and individualisation of mental health problems. Such individualisation has often also been gendered and many feminist scholars have challenged diagnostic and treatment practices for their gendered nature (e.g. L. S. Brown, 2000; Busfield,

1996; Chesler, 1972; Showalter, 1990; Ussher, 1991; Wirth-Cauchon, 2000). These authors have argued that when behaviour is individualised and pathologised, women can be categorised as mad, partly because they act differently from men, and also because the context of their lives is discounted.

Brown (2000) drew attention to the ambivalence in feminist psychology because of roots of feminism in political analysis and of psychology in mental health “epistemic traditions” (p.287). For clinicians, including myself, there is also an ambivalence between the views (not necessarily exclusive) of the individual woman in distress seeking to “ameliorate their distress” (2000) and an awareness of the political factors involved. An attempt was made in the late twentieth century (Lerman, 1986, 1996) to try to synthesise principles of feminist theory and psychological practice. Lerman’s work encompassed diversity and complexity, viewing women in a positive and central manner rather than as ‘other’, valuing the experiences of both client and clinician and supporting feminist, egalitarian and liberatory modes of practice. Brown acknowledged Lerman’s principles and added components which stressed political analysis and the social construction of disorder.

In feminist clinical practice and theorising there is a growing body of published writing which supports the possibility of a social constructionist, feminist approach. This work includes consideration of the way in which subjects are produced by language and practices in discourse. Weedon (1987) for example stresses the place of language in the construction of an individual’s subjectivity. The produced subjectivity is “neither unified nor fixed” but “unlike humanism, which implies a conscious, knowing, unified, rational subject, poststructuralism theorises subjectivity as a site of disunity and conflict, central to the process of political change and to preserving the status quo” (pp.21-22).

Weedon’s view is supported by Lather (1991) who also critiques humanist versions of the self, stating that a postmodern, feminist approach involves “a shift from a romantic view of the self as unchanging, authentic essence to a concept of ‘self’ as a conjunction of diverse social practices produced and positioned socially, without an underlying essence” (p.82). The practices and language which construct women as ‘mad’ and as essentially more likely to be depressed are supported by a patriarchal society and by power imbalances. A number of feminist writers, some of whose work will be discussed in the next section, propose a non-essentialist approach. They maintain that it is possible to address issues of power and knowledge, and maintain a

critical view, attending to issues of social justice without reverting to humanism. Such a standpoint involves an understanding of social constructionist stories of the self, and I will now present parts of those stories relevant to this thesis.

### ***Social-constructionist stories of the self***

Ten years before Renée wrote the words which introduce this chapter, a significant book co-written by five social scientists addressed the issue of the changing view of the self. This book was *Changing the Subject: Psychology, Social Regulation and Subjectivity* (1984) by Henriques, Hollway, Urwin, Venn and Walkerdine. They stated their intention as working “towards a theory of subjectivity” and showing “psychology’s part in the practices of social regulation and administration and how the very notion of ‘individual’ is a product of discourses which have developed through these practices” (p.1).

When I discovered social constructionist, postmodernist, and poststructuralist versions of the self, I found them confusing and troubling but at the same time exciting. I came to appreciate that these views could be compatible with my personal and professional experience. I agreed with Gergen (2000) who suggested that social constructionism offers a transformed conception of the modernist, “quintessentially interior” self (p.100). This transformed understanding of the self/subject takes into account the cultural and historical situation of the self, as well as acknowledging a conception of the self as “a by-product of power/knowledge relations, inseparable from language-games, ideology, mass media, and the moment-to-moment construction (and dissolution) within ongoing relationships” (p.101).

Davies (1991) explained the poststructuralist view of contradictory subjectivity as being constituted through discourses and the positions available to the person at any time through their “own and others’ acts of speaking/writing” (p.43). Davies suggested that the humanist would focus on the individual making coherent choices based on rational thought. The poststructuralist, however, would see desire subverting rational decision-making, and that desires “are integral to the various discourses through which each person is constituted” (p.43). In terms of the person and the collective, humanists would see society’s norms and values being internalised and becoming part of the socialised individual. However, the essence of the individual is what the collective is not. Post-structuralism does not embrace such dualism, rather the individual is seen as constituted through various discourses, and being “spoken into existence” (p.43)

through them. The humanist person is understood to have a continuity of identity in contrast to the poststructuralist fragmented, discontinuous, contradictory subject. The subject does, however, have some continuity through “investment in particular discourses and through embodiment” (p43).

Davies has recently revisited the issue of the “feminist subject in poststructuralist discourse” (Davies et al., 2006, p.87) and the implications of the past thirty years in the Western world for the “transformable subject”. Whilst she reaffirms the “fluid, fragmented” nature of the subject she emphasises the impact of context, especially the impact of neo-liberalism and its conception of an “individualized, competitive, free and responsabilized subject” (p.88). The impact of what she describes as a “commitment to” the “project of competition and survival” (p.89) is likely to be negative for the marginalized members of society, for many women, and for those experiencing individual distress. Davies presents an experiment in collective biography as a way of decomposing and deconstructing subjectivity. She and the five co-authors of the paper attempted to retrieve memories and then use them as data to “produce insights into the processes of subjectification” (p.92). This effort to better understand transformation of the individual subject will be linked to my findings in the final chapters of the thesis. Her work linking narrative and poststructuralist feminist subjects was not published at the time I planned this project.

Although I do not call directly in this thesis on the work of Michel Foucault, I have, within a social constructionist understanding of the person, found useful meaning in Burr’s (1995) explication of his work. She explains three aspects of what it means to be a person. She writes about the person as “discourse-user”, the self as “constructed in language” and the relevance of “subject positions in discourse” (p.90). These three aspects of the person are central to any understanding of the socially constructed self.

Burr (1995) explained that discourse is used “to refer to a systematic, coherent set of images, metaphors and so on that construct an object in a particular way” (p.184). Fox (1997) also offers valuable commentary on Foucault, noting his domination of postmodern philosophy. Fox discusses Foucault’s “ontology of discourse” (p.35), suggesting that discourse is a central concept in Foucault’s work, connected closely to his concern with power/knowledge. No discourse remains static. It is constantly being produced and reproduced through language, technologies and practices. I have already written about the ways that the psychological and medical discourses produce vulnerable, powerless, mentally ill women. A social-constructionist understanding

would emphasise that these are not simply ‘roles’ that women take up. The woman participates in her own production partly through taking up such readily available positions from the dominant discourses. It requires considerable resistance and agency, as well as desire, to take up less available positions, perhaps as a woman who refuses medication, or as a woman who realises and acts upon her knowledge of the reasons for her distress/depression.

The ideas of discourses and available positions, are not unrelated to the narrative approaches that I am about to present. When people tell themselves about themselves they call on stories which ‘feel right’. In an early work, Davies (1991) considered two views of ‘stories’. She presented humanists as assuming stories to be versions of “events that occur in the real world”, with some being true, and others being fictional. The poststructuralist view of stories is that they are all fictions, but they are also the “means by which events are interpreted, made tellable, or even liveable. .... Such fictions providing the substance of lived reality” (p.43).

### ***Narrative stories of the self***

As this thesis has developed over the past six years, I have discovered how well the ideas of narrative psychology fit within my ‘habitus’. These ideas have increasingly informed my clinical practice as a counsellor and since 1994 I have attended numerous workshops by two New Zealand based clinicians, Johnella Bird and David Epston (Bird, 2000, 2004; Epston & White, 1990), both of whom have played a significant part in the development of theory and practice associated with narrative therapy. I will discuss here some of the ideas of the self which inform my clinical practice and which have influenced the approach I have taken to the research reported in this thesis. In Chapter Four I will focus more specifically on theoretical ideas involved in the narrative inquiry approach that I have used for this research.

John Winslade and Gerard Monk (1999) have summarised some ideas underpinning narrative therapy; ideas which draw on themes developed by a range of scholars, including “psychologist Jerome Bruner” and “ethnographer Edward Bruner” and “French historian of systems of thought Michel Foucault” (p.21). Key ideas they discuss are that “human beings live their lives according to stories” and that these stories are “not produced in a vacuum” (p.22). Discourses are “embedded” within the stories and in any society dominant discourses are “kept in place by surveillance and scrutiny” (p.24). O’Grady (2005) discusses the idea of ‘counter-practice’ in narrative

therapy, explaining how therapists can assist people who are subjected to psychiatric “ward rounds” to consider which voices in these contexts are “privileged” and which are “disqualified” (p.107). She refers to Michael White’s assertion that “it appears that even to think the unthinkable goes some way towards undoing the effects of the marginalisation to which people have been subject” (White, 1995, pp.122-123). White was referring to “taken-for-granted” psychiatric practices and ideas which can marginalise people whom professional experts have given the label of mental illness. These ideas have significant implications for the role of the therapist as a participant in a relationship of “identity-making” (O’Grady, 2005, p.108). Johnella Bird in *The Heart’s Narrative* (2000) emphasises the importance of language in therapy, and how it is possible for therapists to use language to “move beyond the shorthand of diagnosis and categorisation” which “subjects people (clients) to institutional categorisations of normal/not normal” and “inevitably ... acts to support dominant institutional values and regimes of meaning” (p.8).

In the practice of therapy informed by narrative ideas, as discussed in the previous paragraph therapeutic conversations can be used to “generate a contextual self” (Bird, 2004, p.5). One context which holds particular relevance to this thesis is that of the professional mental health system, and the expert knowledge that is part of that system. Therapists are able to assist people to challenge “the idea that [mental health professionals] have privileged access to the truth” (White, 1993). In this process Bird suggests that the use of “relational language” is a way to move away from “psychological constructions of identity”, such as “I have good self-esteem”, or “I am a depressed person”. The use of externalising language, such as I have used in this thesis where I write of “depression disrupting a woman’s life”, invites people to shift away from “totalising descriptors” (Bird, 2004, p.222). Bird suggests that this shift in language can enable people to consider the “complex weave” within which they are immersed. This weave “involves the intersection of many factors, including class, culture, gender, sexuality and age” (p.222).

Michael White (1995) discussed the “implications of the metaphor of narrative” for therapy. He stressed how much people work to “make sense” of their lives and to “endow their experiences of life with meaning” (p.216). For many people, however, the stories that dominate their lives are “problem saturated” and the work that takes place in narrative therapy involves in part the deconstruction of these stories and the identification of alternative and preferred stories which can then be strengthened and



thickened. These new stories offer a different and preferred meaning to the person's life (Monk, 1997). From a constructionist and narrative viewpoint it is possible "through conversation" to "make up the possibility of new futures" (Barnes, 2004, p.44). The ongoing reconstruction of a fluid self takes place in a landscape of "structural imbalances of power in society" and Barnes emphasises that we categorise and story the world and our lives the way that we do because we "have participated in social practices, institutions and other forms of symbolic action (that is, language) that give shared meanings to events" (p.44).

In this brief discussion of narrative therapy and some ideas that underpin it I have presented a particular set of clinically related notions that are drawn from the broader field of social constructionist thought. In the last part of this chapter I will present ideas of Edward Sampson and Jane Ussher whose ideas have enabled me to integrate some theory and the associated implications for clinical practice and research.

### ***Integrating the stories of self***

As I have attempted to find an integrated, if complex and contradictory, theoretical underpinning for this thesis, I have found two chapters in different books which have come to my attention at significant times. My reading them each evoked an immediate 'Aha' experience. First I discovered Edward Sampson's chapter in 2001, then I re-read Jane Ussher's chapter in 2005. I had read both of these authors before, and had heard them both present papers. However, it was not until my own thinking had developed a state of readiness, that I realised the significance of their stories to my own narrative.

### **"Beyond constructionism": Edward Sampson**

Edward Sampson (1998) wrote of a significant personal experience which led him to challenge his long held support of both feminist and constructionist movements. His own reaction to a visit to "Yad Vashem, the memorial to the Holocaust in Jerusalem" (p.21) was a very embodied panic, disorientation and confusion. In the months afterwards he worked to "move beyond constructionism" (p.23). In particular he challenged the "verbocentric" aspects of the constructionist model and its "failure to recognize that talk is inherently embodied" (p.24).

The challenge of the ideas of 'being through language' (Sampson, 1998, p.23) connected for me with the dissonance between the theory of social constructionist and even post-modern thinking and my own experience and that of my clients. The insight that we are "discursively constituted" is not lost, nor is the concern at the dualistic

categories of gender and the systems of domination that are often based on such duality (Sampson, 1998, p.23). Sampson turned to Bourdieu's theory about embodied discourse to extend his theoretical understanding so that it took account of his own experience of embodiment. Sampson did not want to "separate the world into one more dualism: in this case, the discursive and the prediscursive". Rather he saw us as "always socialised into a jointly functioning language and embodied community" (p.26).

Through his discussion of his own experience as a person, who is both Jew and intellectual theorist, Sampson (1998) moved me deeply. He acknowledged how much he had been captured by an "ocularcentric spectator's disembodied approach". This position he came to understand as an unwitting "intellectual error in judgement" (Sampson, 1998, p.29). He believed he was calling for an "embodied discourse" – not as just another "intellectualist stance" but as a political commitment for academics and theorists so they do not again build theory on "duality and a hierarchy of mind or spirit over body"(p.31). This call is one I find myself hearing, perhaps not as clearly as I might if I had spent as much time engaging with theory, but with the significance of my own experience as a woman and a clinician.

The call to a theory which recognises the body is in some ways a call from a sophisticated academic to re-think in a way that for me shows clear connection with Mason Durie's explanation of Māori views of self. Jane Ussher's material-discursive-intrapsychic approach (2000a) also recognises the need for a move not only beyond positivism but also beyond social constructionism.

### **An integrated approach? Jane Ussher**

Jane Ussher has published a number of significant articles and books about women, mental health and research (e.g. Ussher, 1991, 1992, 2000a, 2003a, 2003b, 2004, 1997, 2000b) . As I was starting to develop this project I attended two conferences where she spoke, and her views were inspirational for me. I found the ideas I had been considering affirmed and extended. Shortly afterwards she published a chapter in a book which was part of the series 'Inquiries in social construction'.

Ussher (2000a) commented on the "critical stance" of social constructionism toward "taken for granted knowledge" and the way that "such knowledge is sustained by social practices" and its willingness to "acknowledge cultural and historical specificity" (p.216). However, like Edward Sampson she considered that social constructionism and discursive analysis may "negate" material aspects of women's

lives. Amongst the aspects Ussher lists are “the influence of age, social class, power, economic factors, ethnicity, sexual identity, personal relationships and social support, or a prior history of sexual abuse” (p.218). She also notes that social constructionist and discursive approaches may “appear to deny” women’s experienced “‘reality’ of mental health problems” (p.218).

Ussher’s way of moving forward is more comprehensive than Sampson’s. She proposes that the three levels; material, discursive and intrapsychic be “incorporated into theory and practice” (Ussher, 2000a, p.219), asserting that such an approach would be valuable for theory development and for practice. This approach allows cognisance to be taken of the experience of women in a patriarchal society, of intrapsychic factors which can operate at the individual psychological level, and of critical realism. Within the latter she suggests it is possible to “reconcile both biomedical and psycho social aspects of experience, as well as incorporate the cultural and historical context in which the meaning about experience is created” (p.221). In a practical way, for women experiencing depression, for example, it would be possible to acknowledge within such a framework a range of symptoms and a range of responses. Medication would be a possibility, as would alteration of economic circumstances, or a therapeutic approach to psychological symptoms.

The last point that I wish to discuss from Ussher’s article concerns her assertion that the approach she suggests would encourage us to “abandon all attempts to accurately predict single factors that precipitate the onset of symptomatology, or the effectiveness of one treatment over all others, within mental health research” (Ussher, 2000a, p.222). Instead we can within research “utilize whatever methodologies are appropriate to address the research question”. For women experiencing distress which might involve mental health problems we can acknowledge that such problems are “fluid and multifaceted phenomena with many possible etiological routes” and that as a consequence we “should expect to find myriad means of prevention and intervention” (p.223). This approach is solidly in keeping with my project. I am going to explore the narratives of some women who have used things to help them overcome depression that are not normally accepted as mainstream or professional. The analysis of these narratives will add to the ‘myriad’ of responses that are accepted as valid, helpful and worth taking notice of; that the findings will assist some women to live lives that are less disrupted by the experience of depression.

## **Conclusion**

The preface and this chapter are positioned as an entrance way into my thesis. In the preface I explained how my experience and my curiosity had given rise to my research topic. In this chapter I have presented the story of how I arrived at my current understanding of the ‘quirky’ idea of the self. This understanding is complex and at times contradictory, but it has had to be frozen in time as I commit this report of my research project to a written form. This view of the self is the foundation stone for my argument.

The chapter has been a narration of my own story; of how I have found a way to make theoretical meaning of my life as a clinician, a counsellor. It is a meaning made by a Pākehā, New Zealand woman who was born in the nineteen forties and whose ontological and epistemological understanding developed through humanism and essentialism, feminism, and social constructionism to an appreciation of the ‘narrative turn’. I have also developed as a counsellor in the same city where Johnella Bird and David Epston work, write and practise. I have had the privilege of having Johnella as a clinical supervisor for a number of years.

At this point in time, early in the twenty first century in Aotearoa New Zealand, I have called on a number of narratives from philosophers, clinicians and novelists, as well as the spoken stories of my family, friends, colleagues and clients to create my own contradictory, complex ontological and epistemological view. If I had created this thesis thirty years ago, when I first contemplated the process, it would have been a very different thesis. I know that if I were to start it now, rather than in the last year of the twentieth century, it would develop differently. In the same way that the women who have participated in the study have had their narratives captured at a moment in time during the first year of this new century, so my thesis is one moment in my life. The moment has extended over at least five years, and the thesis has grown as I have continued to work full-time as a clinical practitioner. If I had chosen to spend more of life as an academic and read more theory I would probably have had more psycho-dynamic and feminist philosophical stories to draw on to produce my own meaning-making narrative. As it is, my practice is a strong influence, alongside the theory I have read and discussed. This thesis clearly reflects and is informed by my own ‘narrative habitus’.

In Chapters Two and Three I will consider the literature and research about women’s experiences of depression which are most relevant to this thesis. As always,

this will be my selection of what is significant, from amongst the work I have been able to discover, or have encountered in a more serendipitous fashion.

## Chapter Two: Some Pieces of the Jigsaw

*This [critical realist] approach implicitly accepts as legitimate all the questions that the researchers might set out to answer, rather than limiting the research questions because of epistemological or methodological constraints. The results of individual studies could then be seen as pieces within a complex jigsaw that has been fitted together to make sense. The 'integration of piecemeal approaches' ... would not be considered problematic here.*

Jane Ussher (2000a, p.221)

This review of literature about women and depression is necessarily selective. A vast amount of published research exists. Over 100,000 studies about depression were published between 1975 and 1990 (Yapko, 1997, p.37) and there would be at least this number in the following fifteen years. My review is presented in two chapters; Chapter Two which provides a background and involves a discussion of the meaning of the term 'depression', from both professional and lay points of view. Literature about the incidence of depression amongst women is then reviewed before I consider various risk factors linked with depression. The chapter concludes with a review of work on protective factors. In Chapter Three I will review the literature concerning recovery.

In both chapters I have chosen material to review primarily on the basis of relevance to women's experiences of depression. I have included New Zealand research where appropriate. Work which draws on women's experiences is privileged. The participants in this project experienced depression and recovery at different times throughout the last half century, and some historical material will be included enabling their experience to be contextualised.

Ussher's statement introducing this chapter acknowledges the value of different research approaches, and this fits my 'narrative habitus'. She argues for critical realism within her "material-discursive-intrapsychic approach to women's 'madness'":

... findings of existing research on women's madness could be reinterpreted within a critical realist frame; we could legitimately incorporate the results of biomedical experimental research on causation, questionnaire studies, the subjective accounts of women, and deconstruction of wider discursive constructions of madness into one framework. However, in doing so we would have to reject many of the epistemological assumptions underlying individual studies, and the status given to many existing accounts. For example, critical realism explicitly rejects what have been described as the 'predictive pretensions' of natural science: we are dealing with open and not closed systems, and therefore can only explain and describe – not predict.

(Ussher, 2000a, p.222)

In keeping with both this statement and the one at the very beginning of the chapter, I will include reviews of positivist research, but as descriptive information rather than ‘truths’. The first problematic ‘truth’ concerns the word ‘depression’ and the ways it has been used by different theoreticians, researchers, and lay people. In the first section of this chapter I will consider some possible meanings, and explain the ways that I use the term in this thesis.

### ***What does the word ‘depression’ signify?***

As with much of the language related to mental illness, the signification of the term ‘depression’ is contested. The context, the speaker and the audience all impact on the meaning. In the history of human distress, the naming of ‘depression’ and the understanding of it as a mental illness is relatively recent. Busfield (1996) discussed how ‘depression’ evolved from the ‘melancholia’ of the nineteenth century, becoming a “disease label rather than a symptom of disease” (p.93). During the twentieth century depression was sub-categorised into ‘endogenous’ and ‘reactive’, ‘unipolar’ and ‘bipolar’ and by the 1990s as “major depressive episodes” and “less severe affective disorders” (Busfield, 1996, p.91). In this section some currently available meanings, both professional and lay, will be discussed and I will conclude by explaining how ‘depression’ is used in this research.

### **Professional understandings of depression**

Over the last half century the professional use of ‘depression’ has often been based on versions of the DSM including the most recent DSM-IVTR (American Psychiatric Association, 2000). These are professionally respected attempts to classify and define mental illnesses. Currently a diagnosis of major depression requires:

1. **At least 5** of the following symptoms.
2. These symptoms must be **present during the same 2 week period**.
3. These symptoms must **represent a change** from a previous level of functioning.
  - Depressed mood, nearly every day during most of the day.
  - Marked diminished interest or pleasure in almost all activities.
  - Significant weight loss (when not dieting), weight gain, or a change in appetite.
  - Insomnia or hypersomnia (excess sleep).
  - Psychomotor agitation or psychomotor retardation.
  - Fatigue or loss of energy.
  - Feelings of worthlessness or inappropriate guilt.
  - Impaired ability to concentrate or indecisiveness.
  - Recurrent thoughts of death, recurrent suicidal thoughts.

These requirements imply complexity, but assume an “objective reality” that “truly is a diagnosable mental illness” (Rosen, 1996, p.5). Many standardised instruments designed to measure or recognise depression draw on similar assumptions. These tools are informed by the dominant stories of medical naturalism, an influential example being the Beck Depression Inventory (A. Beck, Steer, Ball, & Ranieri, 1996) which has been available in three different forms since 1961.

Systems of diagnosis and classification often accept uncritically the DSM categories which many social constructionists regard as “the view of a socially privileged and credentialed class of adherents of the scientific method” (Duffy, Gillig, Tureen, & Ybarra, 2002, p.364). Diagnostic labels are powerful; they take on the authority of science and of the highly esteemed medical profession. Duffy et al. (2002) commented:

Irrespective of whether one’s clinical training was in medicine, as in the case of psychiatrists, or in cybernetics or systems theory, as in the case of family therapists, the DSM represents the dominant cultural narrative about emotional, behavioural and psychological problems and shapes the thinking and practice of most clinicians (p.363).

Even within scientific psychology the categories for different named forms of mental illness are regularly changing, and the ‘illnesses’ included in the DSM are frequently altered (Drewery, Winslade, & Monk, 2000, p.249).

Although scientists have sought clarity and consistency, Pilgrim and Bentall (1999) suggested that medical ideas about “what depression actually is” seem to be confused (p.261). They accepted that the description of depression as a syndrome “comprising mood disorder, psychomotor changes and a variety of somatic and vegetative states” (p.263) is one way of acknowledging the complexity of the experience of depression. However, they questioned the value of a system which can lead to two or more patients all having a diagnosis of ‘depression’ but having “no symptoms in common” (p.264). Stoppard (2000) expressed reservations about the binary nature of positivist diagnoses and definitions which imply that “the disorder is presumed to be either present or absent” (p.7). Less influential, alternative and more inclusive ‘stories’ are offered by social constructionism and critical realism (Pilgrim & Bentall, 1999; Pilgrim & Rogers, 1997; Ussher, 2000a). As the diagnosis of depression as a reality has been challenged, so this definitional challenge has raised questions about methodological and clinical practices.



It is common, even in qualitative research, to select participants using a standardised measure. Vidler (2005) for example carried out a phenomenological study of women “who had been diagnosed as depressed” because this would enable “comparisons across studies” (p.292). In contrast, Scattolon (2003) trusted women to select themselves for her research if they “identified themselves as depressed, or under a great deal of stress” (p.206); an appropriate approach because she was interested in the experiences of women who had coped with depression “unaided by professional help” (Scattolon & Stoppard, 1999, p.205). The researchers explain that their “feminist standpoint” meant that “rather than defining and assessing depression according to the preconceived notions of ‘experts’” the women’s “personal meanings regarding depression were articulated and their accounts were treated as a valid source of knowledge in their own right” (p.205).

Women’s personal meanings of depression vary, as do lay understandings generally. They are central to my research question, and this thesis will add to knowledge about the meanings non-professionals attribute to the term ‘depression’. In the next section I will review some of the published information about such understandings.

### **‘Lay’ understandings of ‘depression’**

The term ‘lay’ represents a key concept in this thesis. The Oxford Dictionary (Allen, 1990) offers the definition “not professionally qualified, especially in law and medicine” (p.671), acknowledging the power of particular professions in society. In using ‘lay’ throughout this thesis I acknowledge the socially constructed and situated nature of the term, and the way it positions ‘lay’ people as less than the ‘experts’ from the dominant professions of medicine and psychology. Lay people, like the professional experts, draw on available culturally and historically specific stories to name their distress. The chosen stories will fit their narrative habitus, but the choice will be influenced by the power and status attached to some stories more than to others. One way of discerning the dominant stories in a culture is through a study of popular media.

Mental health understandings portrayed in Australian popular women’s magazines were studied by Gattuso, Fullagar and Young (2005) who acknowledged the complex, socially constructed lay understanding of depression. Australia’s mental health promotion strategy aimed to encourage women to recognise depression as an illness, to consult with experts and to have faith in antidepressant medication and

cognitive behavioural therapy (p.1641). Self-help was also advocated, but seen as less effective than ‘expert’ treatment. Gattuso et al. considered that these policies served to construct people who “refuse to take up the expert view of depression as illness” as “non-compliant, ignorant or, in the dominant discourse, illiterate” (p.1641). In contrast, the authors found that women’s magazines privileged explanations of depression as linked to “women’s experiences and struggles with the competing demands on their everyday lives, identities and relationships” (p.1644).

Language used by women in therapy also expresses lay understandings of depression. McMullen (2003) studied “metaphors and other figurative expressions used by “depressed” women as they talk to their psychotherapists about themselves and their lives” (p.18). She found that they constituted themselves and their distress as devalued. They used expressions that were dark, burdened or down, such as “black cloud”, “it’s like I’m carrying a load around”, “down in the dumps” or “the dreary dismal pit” (p.19). Women drew from “culturally embedded discourses of the flawed or deficient self” to construct themselves as suffering a “personal flaw or deficiency” (p.35).

Along with magazines, and therapeutic talk, the published writings of women who have lived with depression reveal non-expert understandings. They include novels, poetry, autobiography and collected volumes of stories, and reflect a range of understandings of ‘depression’. Often the experience is contextualised and holistic. New Zealand collections of stories offer examples from this rich resource. Firstly ‘G’:

Depression and mental illness often result in medication which in turn lessens the will God gave us to “rise up and walk”. And thus laughter becomes a thing of the past and for some it’s only a memory... I was not at that point of time ready to let anyone beyond the wall built up by pain, sorrow, guilt, both true and false and years of spiritual confusion. (Members of the bi-polar support group North Shore and Whangaparaoa support group for mental health, 2000, p.26).

Secondly Mary O’Hagan in *A gift of stories: discovering how to deal with mental illness* (Leibrich, 1999).

Being depressed was like having a whole lot of switches turned off in my brain. I got very slowed down and withdrawn. I would also feel very vulnerable – like I had no skin. Then there were the times when I couldn’t hold a thought in my head – they just got sucked into the blackness. That was scary because life is chaos without words. And all through it was my loss of hope and the terrifying belief that life was meaningless. And you know, it’s an experience where there is only room for one. The isolation was pretty unbearable at times (p. 130).

There is also a growing body of research which presents edited and analysed versions of women's experiences but includes many verbatim accounts. A New Zealand example is *Kia Mauri Tau!* (Lapsley, Nikora, & Black, 2002). The authors summarised the participants' experiences of depression as follows:

This state of mind, with its accompanying feelings of sadness, emotional pain, hopelessness, and lack of energy, was mentioned by more than half of the participants. They used terms such as "badly depressed", "deep sorrow, soul destroying sorrow" and "clinical depression". People referred to not being able to get out of bed, "nothing mattered", "numbness", being a "zombie", as well as "real, deep emotional hurt", anguish, being in a "black hole" and crying a lot (p.26).

Many personal accounts of depression include references to metaphysical concepts which may often be omitted from 'expert' accounts due to the difficulty of assigning a defined meaning to terms such as having "no skin" or to the concept of "soul destroying sorrow". Music can sometimes convey these concepts. Gergen and McNamee (2002) attempted to honour 'lay' understandings when they discussed the "folk tradition" of having "the blues" which they described as "an honorific state; it signifies that one truly knows life and has experienced its depths and defeats" (p.339). This understanding of 'depression' drew on "traditions of the spirit" and the "loss of meaning" of "souls suffering" (p.340).

The difficulties in defining depression should not detract from the distress experienced by many. Rogers, May and Oliver (2001, p.317) offered an important reminder to researchers and theoreticians when they introduced their research into the "separate worlds of patients and doctors" with the following: "However problematic medical concepts of depression are in everyday life, the reality of misery, disability and despair that underpin depressive symptoms are experienced by thousands of people" (p.317).

### **Use of the term 'depression' in this thesis**

I invited women to decide whether their lives have been disrupted by whatever they understood by 'depression' expecting that the experience would not be limited to, but might include features listed by Stoppard (2000):

... the term depression refers to a condition characterizing an individual that encompasses a set of experiences which include "symptoms" such as the following: feelings of sadness, dejection, hopelessness or despair, coupled with extremely pessimistic thoughts about one's self, situation and future prospects; lack of interest or pleasure in activities usually

engaged in, along with social withdrawal; various bodily complaints including aches and pains, difficulty sleeping, fatigue, loss of appetite (or sometimes overeating); and in some cases suicidal thoughts or actions (p.7).

Professional ‘expert’ decisions about what constitutes an illness, and the choice of symptoms which are considered ‘abnormal’ can be gendered decisions. There has been considerable discussion of this matter, especially since the 1970s and second wave feminism. Notable contributions have been made by Chesler (1972), Broverman (1970), Showalter (1990) and Ussher (1991). In the following section I will consider some of the literature which has a particular focus on the question of whether women are more likely than men to experience depression.

### ***Women and depression***

I will begin this section with a review of information about the incidence and prevalence of depression amongst women. I will then explore explanations about the apparent gendered nature of depression. Finally I will discuss research into the causes of depression, particularly in relation to women.

### **How many women’s lives are disrupted by depression?**

Depression is a very common form of diagnosed distress in Western societies. It has been established that women are more likely than men to suffer the symptoms associated with this diagnosis. It seems likely that whatever definition or description is used for depression, it is having a major impact on Western women. Stoppard (2000) stated “information from a range of sources, based on various ways of defining depression, seems to converge on the conclusion that depression indeed is a problem that particularly afflicts women” (p.6).

A Canadian study (Sareen, Cox, Afifi, Yu, & Stein, 2005) reviewed findings from several countries and concluded that 7.3% of the total population had experienced depression which would earn a DSM-IV major depression diagnoses during the year preceding the study (p.757). Twelve month prevalence in the USA has been reported as 6.6% and lifetime prevalence as 16.2% (Kessler et al., 2003, p.3099).

Amongst the substantial number of people presumed to be experiencing major depression, the majority are women. Again the actual numbers reported vary. Alonso et al. (2004) in a survey of 21,425 non-institutionalized adults, found that major depression had a life-time prevalence of 12.8% and a twelve month prevalence of 3.9%.

For women the comparable statistics were 16.5% (8.9% for men) life time prevalence, and 5.0% (2.6% for men) 12 month prevalence. These authors concluded, that “women were twice as likely to suffer ... mood disorders as men” (p.21). Earlier the American Psychological Association’s national task force on women and depression (McGrath, Keita, Strickland, & Russo, 1990) stated that they considered the finding that women are twice as likely as men to experience depression to be “one of the most consistent findings in research literature” (p.xi).

The incidence and prevalence of depression amongst women in New Zealand are similar to those reported elsewhere in the western world. In 1981, 17% of New Zealand women reported “having been depressed recently” (Haines, 1987, p.30). Ten years later the New Zealand National Health Committee (1996) concluded “women are more likely to experience a depressive disorder than men: lifetime prevalence of 19.4% for females, 10% for males” (p.10). In 2001 it was reported that at age 18 years 26.4% of females and 9.7% of males met criteria for a mood disorder (Fergusson & Horwood, 2001, p.290).

If, as the weight of evidence suggests, a gender difference is accepted, then there are a number of possible explanations. Stoppard (2000) considered mainstream explanations for the “predominance of women among the depressed” and grouped them into three major clusters which covered most “complex, multifactorial approaches” (p.10). She concluded:

.... ultimately depression is likely to be explained as arising from some combination of individual biological make-up (genes, biochemistry), psychological characteristics (personality traits), and social conditions (circumstances of everyday life) (p.10).

Stoppard offers an approach which foregrounds women’s experiences of depression and acknowledges the embodied nature of depression. She used Jane Ussher’s term “material-discursive” to name her approach (p.21) and explained that this “perspective begins with the recognition that, like all human experiences, it [depression] is an integrated biopsychosocial phenomenon” (p.21). Stoppard and McMullen (2003) stress the importance of women’s experiences being valued, and urge that their lives are not decontextualised and stripped of their circumstances and everyday activities. Researchers, theoreticians, policy-makers and practitioners need to understand “the situations in which women become depressed” which may necessitate the asking of

questions about “power, about ideologies and practices of gender, and about other social, structural inequities in women’s lives” (p.5).

In the next section of this chapter I will review a variety of literature about the reasons why depression may enter into and disrupt a woman’s life.

### **Why do women get depressed?**

I will now discuss some risk factors which have been linked with depression. Although none of these may be direct ‘causes’ of depression, they point to reasons that may make women vulnerable to this kind of distress. The stories which are used to explain women’s vulnerability will be organised into four groups; bio-medical, psychological, contextualised and material-discursive approaches.

#### ***Biomedical stories of causation***

Genes, hormones and neuro-chemistry dominate bio-medical stories about women and depression. None of these stories offer simple explanations of depression or its causes, but they have all provided available explanations which women may draw on to make sense of their own distress. Lesch (2004) wrote that “depression is a group of brain disorders with varied origins, complex genetics and obscure neurobiology” (p.174). His view supported that of Monkul, Malhi and Soares (2003) who wrote of mood disorders that “although there is little doubt that they are brain-based disorders, their neural correlates still remain elusive” (p.368).

The extent to which depression is familial is also disputed. Sullivan, Neale and Kendler (2000) carried out a meta-analysis of twin and adoption studies and concluded that major depression is “heterogeneous”, and results from “both genetic and environmental factors” (p.1559). Glowinski, Madden, Bucholz, Lynskey and Heath (2003) reviewed this and other studies and suggested that “liability to major depressive disorder in adults” was “approximately 40% due to additive genetic factors” and “60% due to non-shared environmental factors” (p.988). These figures fit within the range of 25% to 50% heritability suggested by Rice, Harold and Thapar (2005). All such findings will be influenced by the sample used, and the measure of depression but as Busfield (1996) pointed out, there are “undoubtedly ... some biochemical correlates of states of depression which are necessary conditions for those states” (p.144). The complex interaction of different factors is only partially understood, but new information is regularly emerging. Caspi et al. (2003), for example, have discovered a

particular gene (5-HTT) which they consider moderates “the influence of stressful life events on depression” (p.386).

In addition to biological theories based on heritability there are many hormonal theories about depression. Studd and Panay (2004) unquestioningly wrote of “the triad of hormone-responsive depressive disorders; postnatal depression, premenstrual depression and peri menopausal depression” (p.338). They argued that “compelling data” supports use of hormone therapy at stages of life where there are major hormonal changes. Other researchers question such a strong conclusion.

Avis (2003) reviewed “menopausal transition” research (p.91). Four theories emerged linking this stage with depression. The first theory posits that depression may result from a ‘domino’ effect which includes the impact of vasomotor symptoms resulting in chronic sleep deprivation. The second that biochemical changes in the brain result directly from decline in oestrogen, the third offers a psychoanalytic view that the loss of fertility is a “threat to adjustment and self-concept” (p.92) and the fourth offers a social circumstances perspective that foregrounds life events and circumstances which coincide with this hormonal stage. Avis concluded that “depression can be viewed as multifaceted and not necessarily caused by only one factor” (p.95). Many others, including Robinson (2001) acknowledge complex causation, but she also concluded from her review that “contrary to the myth that menopause is a time of increased psychological distress in women, the majority of women manage this transition without difficulty” (p.183).

Childbirth is another stage of life when women are commonly believed to be vulnerable to depression. The range of explanations is similar to those offered by Avis. Two contrasting views are represented by Studd and Panay (2004) and Nicolson (2003). The former authors wrote :

Postnatal depression is another example of depression being caused by fluctuations of sex hormones.... There does seem to be a lack of any overall influence of psychosocial background factors in determining vulnerability ... (Studd & Panay, 2004, p.342).

Nicolson, in direct contrast, stated:

It is also evident now that socially isolated women from low socioeconomic status backgrounds, who live in poor housing and have marital difficulties, are more likely to experience depression at this stage of their lives than women who have good social support networks and who come from affluent backgrounds (Nicolson, 2003, p115).

Each author draws on their professional narrative habitus to collect and critique the articles they review. Studd and Panay acknowledged a conflict of interest: they have both “acted in an advisory capacity and lectured for various pharmaceutical companies, including those manufacturing products mentioned in this review” (p.345). In the cited statement they do not make direct reference to any research. Nicolson, on the other hand, supported her statement with a number of published studies.

When women have been interviewed about their experience of postpartum depression they talk of complexity, suggesting involvement of psychosocial reasons, including isolation, along with hormonal changes. They also indicate how much they feel judged for having feelings contrary to the expectations of a society which portrays motherhood as a time of fulfilment and joy. Mauthner (2003) has interviewed many women who have experienced postpartum depression, and commented how willing they were to talk with her, because “I was the first person to express an interest in, and explicitly ask them about, an aspect of their lives they felt was silenced and condemned by society and the people around them” (p.90).

The causes of premenstrual mood changes are likewise disputed. Many factors contribute to society’s ‘construction’ of menstruating women. Powerful, readily available discourses about menstruation involve ‘trivialisation’ and ‘pathologisation’ (Bendall, 1994, p.19) and are in opposition to marginalised discourses within which menstruating women might position themselves as normal and healthy. Men’s expectation that women will hide menstruation from them is one action which constructs menstruating women as ‘dirty’ and ‘shameful’ (Martin, 1992, p.94), and may contribute to feelings of worthlessness and depression.

Busfield (1996) has come to an understandable conclusion about biological stories of depression which focus on the body. They tell only a “very partial (if not inaccurate)” explanatory story of depression (p.145). In the research where women have been consulted about their understanding of their depression at times of hormonal change they present much more complex stories. These stories often overlap and intertwine with stories discussed in the next section; stories from women’s psychological, social and historical landscape.

### ***Psychological stories of causation***

There are many psychological theories of depression. I have selected some influential ones, including Seligman’s theory of ‘learned helplessness’ (Peterson & Seligman,



1985). The ideas of Beck (1993) and the diathesis-stress explanation of depression and psycho-dynamic based feminist theories exemplified by the work of Dana Jack (1991) serve as a bridge between individual psychological understandings, and explanations that focus more on social context.

Cognitive behavioural explanations for the development and persistence of depression have achieved prominence and provide the theoretical underpinning for the widely recommended psychological treatment, cognitive behavioural therapy (CBT) (National Health Committee, 1996). Learned helplessness is one of these theories developed in the 1960s (Cemalcilar, Canbeyli, & Sunar, 2003). Cemalcilar et al. explain the phenomenon: “when experience with uncontrollable events leads to the expectation that future events will also be uncontrollable, disruption in motivation, emotion, and learning may occur” (p.65). Much of the development of the theory has been carried out by Seligman (Abramson, Metalsky, & Alloy, 1989; Peterson, Maier, & Seligman, 1993; Peterson & Seligman, 1985), whose earlier ideas were reformulated by Abramson (Abramson, Metalsky, & Alloy, 1989). Abramson’s theory proposes a “*specific* constellation of depressive symptoms, termed ‘hopelessness depression’ (p.360). A distinction is made between different attributional styles suggesting that people who are inclined to interpret bad events in internal terms tend to helplessness and depression. They attribute causation for such events to themselves, and expect them to continue for ever.

Aaron Beck (1993) developed cognitive theory which focussed on the ways that a pervasive negative bias and a prominent theme of defeat predisposed individuals to depression. He also identified as influential a range of erroneous beliefs and maladaptive information processing (Hollon, Shelton, & Davis, 1990). Whilst Beck concentrated on current behaviour and thinking patterns, he believed early experience can shape the development of a negative schema which then acts like a template, interpreting external stimuli in an unrealistically negative way. He proposed a negative triad, with any individual suffering from depression tending to see themselves as “unworthy, incapable and undesirable” (Sacco & Beck, 1985, p.5). These feelings can be triggered in susceptible individuals by stressful incidents or situations. Beck proposed that dysfunctional negative schemata are linked through cognitive distortions to unhelpful and ‘depressing’ automatic thoughts.

It has been suggested that “in cognitive theories ... helplessness and hopelessness are considered as trait factors mediating the onset of a depression

triggered by a life event and are regarded as a symptom factor responsible for the maintenance of a depressive episode” (Henkel, Bussfeld, Moller, & Hegerl, 2002, p.245). This diathesis-stress model is in contrast to the biological perspective, discussed in the previous section which focuses on helplessness and hopelessness as symptoms caused by a depressive disorder.

Henkel et al. (2002) reviewed cognitive-behavioural theories related to depression, making it clear that much research supporting the theory of learned helplessness had been carried out with animals, and that when humans were studied they had often been university students with only mild levels of depression. When they considered the implications for therapy the limitations of these theoretical models were clear. Cognitive theories do not include ideas of the unconscious, which are a part of psychoanalytic theories, including those of Dana Jack which will now be discussed.

I have included Jack’s work in this section with some hesitation, because she is a critical feminist and her theories mirror the multi-faceted nature of depression, acknowledging the importance of psychological, biological and psychosocial factors (Jack, 1991, p.2). She does, however, draw on psychodynamic understandings from attachment theory and from self-in-relation theory. Thompson (1995) concluded that Jack:

believed that women learn that they will not be loved for who they are but, rather, for how well they meet the needs of others. Further, women learn that the way to meet the needs of others is to deny the importance of their own needs and feelings and to inhibit self-expression (p.338).

Jack talked with women about their experiences of depression, adding a different knowledge to that gained by animal studies or by human research using observation, questionnaires or hypothesis testing. She noted that at the time of her initial research “we rarely hear depressed women’s own words” (Jack, 1991, p.4). Jack suggested that political power plays a major part in constructing the depressed woman, contributing to women’s experience of two selves. These could be named as the “outwardly conforming, compliant self” who conforms to what her male partner expects according to the dominant discourse of woman’s role, and the “secret self who is enraged and resentful” that many of her needs remain unmet and her attempts at intimacy ‘frustrated’ (p.168). Jack suggests that this aspect of depression can be seen as an issue of societal responsibility as well as one requiring social, psychological, bio-chemical, and medical change (pp.183-206).

Thompson (1995) explored Jack's theory of 'silencing the self' in a study of 155 cohabiting women and men and found that silencing the self was "significantly more closely correlated to depressive symptomatology for women than for men" (p.348). She connected these findings with the "centrality of relationship to women's identity and development" (p.349). It is possible that this intertwining of relationship, identity and silencing of the self contributes to the prevalence of depression in women.

Stoppard (2000) discussed Jack's theory in terms of the 'relational self'. She suggested that from such a perspective:

.... depressive experiences are the outcome of a woman's realization that she has "lost herself" in a failed effort to establish and maintain a connection with her relationship partner. The experiences called depression, therefore, are the psychological consequences of a woman's inability to develop her relational self (p.64).

Jack's more recent work has focussed on women's anger (Jack, 2001, 2003). She proposed that for many women "silenced anger transforms into depression" (2003, p.63). Her argument continues to be based around the centrality of relationship in women's lives and while acknowledging the critical role of individual psychology and of bio-chemical explanations of depression, she considered it most likely that "from an interpersonal perspective, depression occurs when a person feels hopeless about the possibility of interpersonal closeness with others" (p.66). Anger and its appropriate or inappropriate expression are linked with the success or lack of success of such relationships and thus with depression. Jack described anger as a "vital, energizing force for change" which can go "awry" (p.84). The "anger of hope" can break down barriers to connection, but the "anger of despair" is turned inward leading to the feelings of "hopelessness and helplessness" which lie at the "heart of depression" (p.84).

Stoppard (2000) acknowledged that Jack's theory does not conceptualise the personality attributes assessed by her Silencing the Self Scale as "stable traits", but considers "self-silencing beliefs" and the "behaviours which stem from them" to be "reflexive" and "shaped by a woman's social context and specific relationships" (p.66). Jack's work bridges the artificial divide I have used to structure this chapter – involving intra-personal theory and the social and relational landscape in stories of the development of depression. Other contextualised stories of depression will now be reviewed.

### ***Contextualised Stories of Causation***

Stoppard (1997) used the terms ‘women’s bodies’ and ‘women’s lives’ to denote the two “main contemporary approaches to explaining depression in women” (p.10). The previous two sections have focussed on medicalised bodies and psychological minds. This section will consider women’s lives and the landscapes within which they are lived. Jack’s work, just discussed, centres around women’s relationships, especially with intimate partners, and how silencing of the self has implications for women’s vulnerability to depression. The context of violent relationships creates an even greater risk for depression, and women who experience any form of violence in childhood or as adults have increased vulnerability to depression.

The violent events that happen to women, and are mostly carried out by men, provide an understandable reason for women experiencing more depression than men. According to Koss, Herrera and Lichter (2003) “at least one woman in three globally is beaten, coerced into sex, or otherwise abused in her lifetime” (p.130) and women “represent 85% of the victims of the one million incidents of nonfatal intimate assaults that occur each year in the US” (p.130). Depression and post traumatic stress are the “two predominant psychological responses” occurring in survivors of male violence (p.130). Koss et al. suggest that the “vexing question” of the “gender gap” in depression research, might be “illuminated” by investigating the “gender differences in vulnerability to intimate violence at every stage of the lifespan” (p.135).

The particular violence of childhood sexual abuse results in adult female survivors having an elevated risk of depression. Dickinson et al. (1999) found that women who were severely sexually abused in childhood were 5.3 times more likely to experience major depression and 3.3 times more likely to experience dysthymia than other women. Sexual violence in adult life including rape within marital and cohabiting relationships, has been shown to have an association with depression, although this is less than that for childhood sexual victimization (Koss, Herrera, & Lichter, 2003, p.133).

Partner violence also increases vulnerability to depression. Golding (1999) carried out a meta-analysis and found that 48% of battered women experienced depression. A Spanish study (Pico-Alfonso et al., 2006) found that psychological violence within intimate personal relationships was as strongly linked with depressive symptoms as physical violence. The authors concluded that psychological, physical and sexual intimate male partner violence should all be considered as having an impact on

women's mental health "that deserves the full attention of researchers, clinicians, lawyers, and policymakers" (p.609).

Violence is a leading risk factor, but there are a number of other significant contextual issues. In New Zealand the National Health Committee (1996, p.12) reviewed international depression literature and concluded that there is a complex interaction amongst the following risk factors:

- Stressful life events and difficulties in the last three months, e.g. financial difficulties
- History of traumatic events, including abuse (physical, sexual and emotional), divorce and social isolation
- Exposure to dysfunctional parenting
- Premature parental loss
- Previous history of depression
- Genetic factors
- Neuroticism (as defined by the Eysenck Personality Inventory)
- Poor social support

Whilst this list includes genetic and psychological factors the majority of risk factors are contextual. The American Psychological Association's National Task Force on Women and Depression (McGrath, Keita, Strickland, & Russo, 1990) suggested (p.45) that assessment of risk of depression in women should follow a schedule divided into three sections; current risk, historical risk and contextual factors. They included "membership in oppressed and marginalized groups", and "race, class, sexual orientation, cultural/religious background, and current status". This schedule reflects issues raised earlier in New Zealand by Esler (1988) who reported that married women were twice as likely as their husbands to suffer from depression and that associated risk factors included membership of a low socio-economic group, having pre-school children and lacking paid employment and close confidants.

In 2000 The American Psychological Association convened an inter-disciplinary Summit on Women and Depression (Nolen-Hoeksema & Keita, 2003). The importance of context was acknowledged in the conclusion that most studies indicate "that the causes of depression in women and men are not different, but that women suffer these causes more than men do" (p.89). In the western world financial hardship is one such factor. Belle and Doucet (2003) contributed to the Summit, focusing on poverty, inequality and discrimination as sources of depression. Poverty is not evenly distributed across gender and ethnicity. In the U.S. "nearly a fourth of Black and Hispanic women live in poverty, and over a third of women who head their own

households are poor” (Belle & Doucet, 2003, p.101). The relevance of these findings to this thesis is that “poverty is one of the most consistent correlates of depression” (p.102). New Zealand research suggests patterns similar to those in the US. A prospective community study of factors that might interrupt long term remission of non-psychotic psychiatric disorders, especially depression, found only one event which yielded a statistically significant correlation – having a major financial crisis (Romans, Walton, McNoe, Herbison, & Mullen, 1993). In New Zealand amongst the groups of people most likely to experience financial hardship are single parents, who are usually mothers, Māori and people from the Pacific Islands (Baker, 2002; Hyman, 1994; Waring, 1988).

A vulnerability factor closely related to financial hardship and responsibilities of single parenting has been researched (Walters, 1991, 1993; Walters, Avotri, & Charles, 2003). Walters and her colleagues explored the cost of women’s caring for others and the work they often do on behalf of others and linked this with susceptibility to depression.

Further significant vulnerability factors include social isolation and loss of significant relationships. George Brown and Tirril Harris have contributed significant research and theory about these issues. Since the 1970s they have studied women and depression, focussing on the effects of social context. The significance of the body of work produced by them and their colleagues is widely recognised (e.g. Busfield, 1996, p.196; Stoppard, 2000, p.74). In their book on the social origins of depression (G. W. Brown & Harris, 1978) they presented a theoretical model which minimised the relevance of biology and introduced the concept of ‘vulnerability’ as a “situationally generated” factor, which could interact with “provoking agents” to result in depression (p.48). Vulnerability and the ability to cope with stress were, they asserted, not “inherent”, but developed in a social context including class, family and intimate relationships (Busfield, 1996, p.196).

Brown, Harris and their colleagues have acknowledged the ongoing difficulties faced by women, including the stresses associated with inadequate housing, poor financial circumstances and responsibilities associated with children (e.g. G. W. Brown, Adler, & Bifulco, 1988). Their theory included vulnerability factors already discussed but also noted the importance of “loss and disappointment” shortly before the onset of depression (G. W. Brown, Harris, & Hepworth, 1994, p.525). In 2003 Harris reviewed research about “depression in women and its sequelae” (Harris, 2003). Brown

and Harris' model was refined to recognise the significance of severe life events involving "loss, either of person, object or of a cherished idea, such as the idea of one's child's honesty or spouse's fidelity" (p.104). Where such losses were associated with depression they usually involved humiliation. Thus "ongoing problems of interpersonal conflict" with the implication of being "put down" by another person were "much more closely associated" with depression than "severe difficulties involving physical health" which did not bring shame or humiliation (p.104). The combination of these losses with vulnerability increases the likelihood of depression. The vulnerability is complex and depends on the "quality of supportive relationships" and their availability at the relevant times of humiliation. The other significant vulnerability factor involves psychological characteristics including "low self-esteem" and "helplessness" (p.104).

As well as life events and psychological variables, Harris (2003) considered the broader context of what she terms the "outer outer world" (p.105). This includes the changing historical context, such as the "change in the context of women in the labour market and in the ease of planning family size" (p.105). Such changes have an impact on the body of research she is reviewing, making the early work of herself, George Brown and associates less relevant and replicable in the later parts of the twentieth century. Busfield (1996) reviewed work from the Brown and Harris researchers and noted that their model recognises the socially constructed nature of vulnerability based on gender, with women having more vulnerability. She also commented that vulnerability is class related with "working-class women shown to be more likely than middle-class women to be in situations where they were vulnerable to severe events and major difficulties" (p. 197). These contextual issues have been linked to psychological factors developed by Jack, with evidence suggesting that difficult social experiences such as abuse, poverty and parenting alone all impact on 'silencing the self' scores, increasing vulnerability to depression (Jack & Dill, 1992; Stoppard & Gammell, 2003).

The work of Brown and Harris, and that of Jack, as well as other research reviewed in this section do take account of the complexity of depression, and remind us that women's lives are situated in an historical and cultural context where issues of power, marginalisation and discrimination have a major impact. In the final part of this discussion of stories of causation I will specifically consider the material-discursive approach advocated by Stoppard (1998).

***Material-discursive approaches to understanding how so many women come to have their lives disrupted by depression***

Stoppard (2000) recognised both the worth and the shortcomings of the explanations for depression that I have reviewed, but suggested consideration of research where women's bodies are made visible and incorporated into understandings which draw on women's accounts of their experiences of depression. She and Linda McMullen collected such work into *Situating Sadness* a collection of writing on "women and depression in social context" (Stoppard & McMullen, 2003). This approach is compatible with that of Jane Ussher which was discussed earlier (Ussher, 2004, 1997) and is informed by a social constructionist, critical and feminist understanding.

Stoppard (2000) proposed a view where women's bodies can be conceptualised as "being immersed in culture" and transcending "dualistic forms of thinking" such as "body-mind" and "nature-culture" dichotomies (p.91). This approach results in understandings of 'causation' which are complex, and where it is unlikely that a 'one size fits all' theory will emerge. Susan Hurst (2003) carried out such research, interviewing seven women in her search to understand "the complexity of factors in their lives that had resulted in depression, including the social context in which their personal experiences were embedded" (p.139). She developed a theory that all these women had shared an experience of "being betrayed within their most significant relationships" and that this was often coupled with a feeling of "being left out of the world" and "becoming demoralised" (p.142). Betrayal and demoralisation resulted from diverse experiences such as childhood abuse, or being disrespected and abandoned by their husbands. The women felt they could do nothing, had no control over their lives, and that nothing was ever going to get better. Hurst's research acknowledges context and respects meanings women give to events and relationships, as do a number of other researchers, many of whom have drawn on the knowledge of women who have lived with depression. Rita Schreiber (1996a, 1996b, 1998, 2001) is one researcher who has committed many years to studying women and their experiences of depression.

In 2001, Schreiber published results of three studies involving more than 70 interviews with women (Schreiber, 2001). She critiqued research which had "'problematize[d]" women's experience, reducing it to a contextualized individual pathology" and stressed that "depression is far too complex to be explained in such simplistic terms" (p.86). Schreiber based her work on the philosophical understandings of symbolic interactionism "in which meanings of objects, rather than being intrinsic,



are thought to be developed through human interaction. Interaction is also seen to occur within the self” (p.86). Internal dialogues were revealed as a significant feature of the talk of the women in the study, with the implication that self is “a process of interaction” (p.87). The women became aware of the contrast between their own sense of coherence and the expectations and moral judgements of society and significant others. This disjunct was part of the experience of depression, and its cause. The expectations of conforming to stories of the ‘good’ woman and being “selfless, self-sacrificing, making others look good, not showing vulnerability, being cheerful, being productive, and, above all, being strong” added to the strain of being part of a “devalued visible minority” (p.88). Losses were also significant, as they were in the previously discussed work of Brown and Harris and they were often symbolic, including the “loss of innocent childhood resulting from abuse”, “difficult marriages, disappointing children” and the “loss of an imagined future” (p.89).

The complex interactions that Schreiber (2001) discerned were discovered by using a research method which honoured the women’s knowledge and studied their talk in depth and detail. Thus the widely reported findings of the connection between sexual abuse and depression are deepened by her finding that “from the women’s perspective, the experience of sexual abuse was of a profound sense of pain, fear and despair” (p.91). Schreiber’s work enables us to explore complex interactions such as the “impact of oppression on the everyday lives of women” and to consider the “social structures that promote depression in women” rather than focussing on it as “an individual affliction” (p.97). At the same time we can become profoundly aware of the personal misery and pain of depression.

Clearly there are no simple explanations for why depression disrupts the lives of so many women, nor why it afflicts one woman and not another. However, some life experiences increase vulnerability, especially those which involve violence and those which involve the devaluing of women. Stoppard and McMullen (2003) have provided a valuable collection of research which respects this complexity whilst at the same time enabling increased understanding of factors which may have causal links with depression. There are also resilience factors; things which can buffer women from the worst impact of life events and make it less likely that depression will seriously disrupt their lives. I will now review selected literature about such potentially protective factors.

## **Protective factors**

The feminist and critical realist work that has already been reviewed has emphasised the importance of understanding how depression develops within a landscape of economic and political conditions which frequently “operate to maintain existing gender arrangements” (Stoppard, 2000, p.71) increasing women’s vulnerability to depression. Thus the most important preventative and protective changes would be to alter this landscape. Vidler (2005) reviewed qualitative research about women and depression and found common themes, many implying a need for external rather than personal change.

Women experiencing a loss of control over their lives, a sense of powerlessness, a lack of confidence, a challenge to previously held views of self, distress regarding feelings of entrapment in roles pertaining to the gendered division of labour, attempting to meet the expectations of others by being the ‘good mother/woman’, a lack of access to financial independence, negative and stressful life events, depression within a relational context, and desire to be involved in their own treatment plans (p.291).

Structural and political changes would make it less likely that women would be the victims of violence, discrimination or damaging expectations.

Whilst in the long term it is important to strive for political and societal changes which will reduce the marginalized and disempowered position of many women, there may be short term value in considering more individualised ways of strengthening resilience. Much of the writing about protective factors and depression has focussed on individual women. Vidler mentioned ‘social support’ (2005, p.291) and this is one of the factors most frequently associated with resilience. In New Zealand, the National Health Committee produced guidelines for the treatment of depression and listed the following protective factors which they considered most significant, after reviewing current research:

- Perceived parental warmth
- Social support
- Coping skills and personality style

(National Health Committee, 1996, p.12)

Clarke and Jensen (1997) found social support to be “negatively related to psychiatric symptoms such as depression” (p.303), although their review of 55 studies found about a third where social support did not have a buffering effect. The issue is contested and some contradiction in findings may stem from different understandings of social

support. They noted that “the perception of being helped did not seem to be the result of having large social networks or more frequent contacts” (p.307). In their New Zealand study they took account of the effects of “sex, ethnicity, age, and socioeconomic status” in three environments: “rural, town and city” (p.308). They used a survey, not interviews but took into account such understandings as “married couples may not perceive spouses as a source of support, but rather a source of stress” (p.310). They found social support had no significant buffering effect between life events and depression, but did find gender differences such as “having relatives nearby *who could help* and belonging to a church were important for women, while belonging to a club was important for men” (p.316). They also found unexpectedly high levels of depression among the middle-aged, despite social support and wondered about the relevance of this being an unstable time of life where some people may feel it is “too late to make something of their lives” (p.317). Living in a city, rather than a rural area or town, was a buffering factor for Māori and young people. Such particular findings, and the speculation about reasons suggests a need for qualitative research to discover more about the meanings of life factors for the participants.

Coker et al. (2002) carried out specific research to find whether social support was a protective factor against the negative effects of intimate partner violence (IPV) on mental health. Their survey of 1152 women in the USA led them to conclude that “if women experiencing IPV disclose the abuse and receive support to address the abuse, abused women will be at a significantly reduced risk of adverse mental health outcomes” (p.472). The abused women with higher levels of social support were also less likely to attempt suicide, and this finding is consistent with that of Kaslow et al. (1998). Heilemann, Frutos, Lee and Kury (2004) studied protective and strength factors for another particular group; childbearing women of Mexican descent in the USA, and found that holding spiritual beliefs, having a sense of personal mastery and living in a household with a greater number of other adults were all correlated with less likelihood of developing symptoms of depression.

Aspects of cognitive style are frequently reported to protect against depression. Hawkins and Miller (2003) evaluated positive and negative attributional styles and their contribution to psychological distress. They were interested in the cognitive theories of Abramson (1989) and Beck (1993), especially the proposal that “depression-prone people tend to attribute negative events to internal, stable, and global reasons such as ascribing their inability to gain a job to personal laziness”, and positive events to

“external, unstable and specific reasons such as ascribing the possibility of sudden wealth to luck”(p.176). In contrast to these attributional styles which may be linked with vulnerability to depression, optimism may offer resilience to depression. The research carried out by Hawkins and Miller demonstrated a complex interaction between these factors, suggesting a likelihood that “an optimistic attributional style, which could be promoted in therapy by “behavioural techniques to increase engagement in simple and pleasant activities” (p.181) could buffer against the development or re-development of depression.

Physical activity is another possible protective factor, and again the connections are complex and may be gender related. Bhui and Fletcher (2000) found that physical activity of long duration had a protective effect on mood for men, but that there was “no such protection for women” (p.28). The same study found that “low-intensity exercise for long periods of time is beneficial”, with “a 28% reduction in morbidity for women” (p.33). Leisure activities generally as protective factors in women’s mental health were studied by Pondé and Santana (2000) in a community-based, cross-sectional study of 552 “female adult workers” in a poor city neighbourhood in Brazil (p.457). They asked the women about their “days off” from both paid and unpaid work, recognising how many women, especially those living in poverty, spent a lot of time “taking care of children, cleaning, cooking, washing clothes etc” (p.461). The majority of women (46.8%) did not take time out, but those who did were less likely to experience the symptoms of anxiety and depression. This was particularly the case for women who reported “no job satisfaction and low family income” (p.465). This study links well with the earlier suggestion that changing the landscape can make a difference to women’s vulnerability to depression. Those women who were satisfied in their work, did not have family commitments, and were able to take time for themselves were less likely to have symptoms of depression.

In Australia efforts have been made to incorporate knowledge about protective factors into a school programme (Spence et al., 2005) which involves both individual and environmental factors. The individual factors focus on problem-solving, coping and social skills as well as positive thinking style, and the environmental factors attempt to improve security and safety, social support and positive relationships and social connectedness and participation. This universal, rather than targeted intervention programme offers a framework for a multi-faceted approach to the prevention of “the development of this disabling condition [depression] before its onset” (p.163). It is too

early to demonstrate the effectiveness of this programme, but it does focus on the landscape as well as the individual.

Most people do not have the benefit of a preventative programme in their adolescence but those women who do not escape the distress of depression may still live through it and recover a meaningful life. Many women have possibilities for resilience even when these are not deliberately developed by a programme such as that just reviewed.

## ***Conclusion***

This chapter has reviewed the background literature about the impact of depression on women, and also about factors which seem to make women more susceptible or more resilient. I have argued that when depression is understood as an individual illness or weakness the scope for understanding this form of distress is limited. Research which values the knowing of lay people, (especially those with a profound experience of their life being disrupted by depression), has much more scope for making sense of this complex 'entity'. It seems most likely that depression enters women's lives as a consequence of interactional and dialogical processes often gendered in nature. These processes occur within a complex landscape which involves power that may be acted out in language and behaviour.

When this complexity is recognised it is not surprising that recovery from depression is equally complex, and necessitates consideration of matters beyond the individual woman. In Chapter Three I will review literature related to recovery.

## Chapter Three: Coping and Recovering

*They'd have these support groups and there'd be women there that were from all walks of life that were different nationality, they could hardly speak English and they were different ages and ah, and they were there for different reasons .... It was exhilarating, my god .... Like it wasn't all depressing, but it just made you realize how vast the problems in life are and you see how they coped and how they survived.*

Mary, cited in Scattolon, "I just went on", (2003)

The woman whose words open this chapter was a participant in Yvette Scattolon's study of rural Canadian women's experience of living with and managing depression (Scattolon, 2003). I did not find a report of this research until after I had planned my study and collected my data. When I first saw it my response was "Help! Someone else has done my research already!" When I read it further I realised that she had a different research question from mine; the women in her study who coped with depression without professional help had done so because that help was not readily available. In my study the women have often rejected available professional help and chosen or discovered other ways to recover. Nevertheless the stories involved in Scattolon's study are inspirational, as are many of the reports of women coping and recovering which I will review in this chapter. All are very relevant to my project.

Mary's wonder and exhilaration at the value of female group support emphasises how personal and emotional the recovery process can be. This thesis explores this process particularly in relation to women who find their own solutions. In Chapter Two I explored the language of 'depression' because contestable and shifting meanings are very relevant to a study which focuses on an analysis of stories and thus of language. In this chapter, Coping and Recovering, I will again be considering language, but now in relation to recovery. After a review of literature about rates of recovery, I will consider professional medical and psychological 'cures' and their effectiveness, and follow with a discussion of barriers to seeking or utilising such professional support. In the final and major part of this chapter I will review more complex approaches to recovery, including findings from qualitative research, forms of 'complementary' treatment and strategies which do not involve mainstream professional experts. As in Chapter Two decisions about material reviewed have been made primarily on their relevance to my topic, which is focussed on women's experiences of depression and recovery. More particularly the emphasis is on effective

responses to depression from outside the mainstream of professional medicine or psychology.

## ***Understanding recovery***

### **What does recovery mean?**

As with the word ‘depression’ the meaning of the word ‘recovery’ is contestable. When I began this study I decided to advertise using the somewhat clumsy phrase “women whose lives are no longer seriously disrupted by depression”. I did this to emphasise that many women continue to experience symptoms of depression, but find ways to cope that enable them to live without major disruption.

Mental health researchers have made different decisions about the language to use in relation to ‘recovery’ since I began this project early in 2000. If I had encountered earlier some of the arguments published since my research began I may have used different language from the outset. Stoppard, (2000, p.185) argues for the term ‘overcoming’ in a way that is congruent with the philosophy, beliefs and values which underpin my thesis. She challenges the ideas of women ‘having depression’ and the way that this situates a problem within an individual, implying that depression is a ‘health’ problem which would need to be treated by an expert, especially a medical expert. Within New Zealand a “recovery vision” has become “integral” to the “national mental health policy” (Goldsack, Reet, Lapsley, & Gingell, 2005). In this vision, recovery is not centred on the individual and is “understood as being assisted by social and organisational processes that are far broader than mental health services alone” (p.1). For a number of the service users interviewed by Goldsack et al. recovery “was measured by the extent to which they had got back into their normal daily life” (p.23). The Mental Health Commission (O'Hagan, 2001) has defined recovery as: “the ability to live well in the presence or absence of one’s mental illness (or whatever people choose to name their experience). Each person with mental illness needs to define for themselves what ‘living well’ means to them” (p.5). It is in this sense that I will use ‘recovery’ as I discuss literature and later in the thesis, the findings of my research.

### **How many women recover from ‘depression’?**

Once stories about the distress which is called depression become a part of the common ‘narrative habitus’, then the associated recovery stories also become readily available. Positivist researchers, in particular, having found ways to diagnose and then measure

depression, developed consistent ways to measure recovery. Within this kind of understanding there are a large number of studies purporting to measure the rates of chronicity, recovery, relapse and remission. The ‘grand narrative’ that may emerge from these studies is not one of certain cure, but nor is it one of common chronicity.

One study from the Brown and Harris group (G. W. Brown & Moran, 1994) suggested that at the extremes, 20% of women diagnosed with depression recover and remain well over the next 15 years, another 20% remain incapacitated or commit suicide (p.447). More recent figures summarised by Skärsäter et al. (2005) suggest that “although some people only suffer a single episode of major depression, it is estimated that over 50% will eventually have another, and 25% will have a chronic depressive disorder of more than 2 years of duration” (p.258). These figures suggest that about one fifth of people might completely recover from a major depression episode, without a relapse. The research around factors which might assist full or partial recovery offers similarly disputed figures. What is clear is that it is possible to overcome this form of distress.

Research about ways to enable such recovery will now be reviewed, starting with mainstream professional solutions from medicine and bio-chemistry. Reviews of professional psychological pathways to recovery will follow, and then I will briefly consider combined ‘treatment’ strategies. From then on the chapter will focus on research about pathways to recovery that come from outside the mainstream professional solutions. The review will cover complementary therapies, self-help, social support and groups, physical exercise and nutrition and coping without help. I will then review literature about help-seeking and barriers to receiving or seeking professional help. In the concluding section of the chapter I will discuss how changes to women’s lives can impact on recovery from depression, including a review of research focussed on women’s recovery stories.

At the end of the chapter I will position my own research within the further research needed into women’s recovery from depression.

### **Biomedical paths to recovery**

The most common bio-medical treatment is antidepressant medication (ADM) which has been the treatment of choice in the Western world for many decades. In the USA between 1987 and 2001 the percentage of patients diagnosed with depression who were treated with ADM rose from 70% to 89% (Stafford, MacDonald, & Finkelstein, 2001).



Harris (2003), reviewing research on women and depression, noted that guidelines on treatment were still “focusing on prescribing antidepressant drugs and more purely psychological treatments such as cognitive behavioural therapy (CBT)” (p.109). This advice was also included in the New Zealand Guidelines for the treatment of depression (National Health Committee, 1996).

Antidepressant medication has developed since the 1950s when there was a chance discovery of drugs that either induced depression or gave substantial relief from its symptoms (Nolen-Hoeksema, 1990). Since then two major types of medication, both of which act on neurotransmitters, have been used. The tricyclics which act on serotonin and norepinephrine has been used for decades, and more recently selective serotonin reuptake inhibitors (SSRIs) have been developed. The SSRIs have become the most commonly used medication for major depression, at least in Canada (C. A. Beck et al., 2005). Less widely used are the relatively recent monoamine oxidase inhibitors (MAOIs). There is little doubt that medication provides symptom relief for many sufferers from depression. Rupke, Blecke and Renfrow (2006) suggest that “two-thirds of patients with depression are treated successfully with medication alone” (p.83). Spencer and Nashelsky (2005) noted that “prescription antidepressants are effective at all levels of severity, but systematic reviews have shown no differences in outcomes between any classes of antidepressants” (p.2309). In contrast Joyce et al. (2002) found that the SSRI fluoxetine was more likely to be associated with recovery from major depression than nortriptyline. In a follow up to this study (Joyce, Mulder, Luty, McKenzie, & Rae, 2003) it was found that age and gender were critical variables. “Melancholic depressed patients, aged 18 – 24 years, especially women, had a markedly superior response to fluoxetine” (p.20).

Since my study does not focus on the use of medication, it is sufficient to note that there is no conclusive evidence supporting any particular type of antidepressant medication for any form of depression, or any age or gender of ‘patient’. In addition, whatever the benefits, there are problems with ‘non-compliance’. Many women are reluctant to take ADMs for a variety of reasons, some of which will be reviewed when I discuss barriers to professional treatment. MacQueen and Chokka (2004) acknowledged the concerns that exist about taking medication for depression during pregnancy and breastfeeding, but believed that ADMs were “safe and efficacious during these periods, while untreated depression has negative consequences for both mother and child” (p.27S).

Another significant form of biomedical treatment is electroconvulsive therapy (ECT). In New Zealand this treatment has been the subject of a Ministry of Health review (Ministry of Health, 2004) which recommended that ECT be available as a choice for treatment of “severe depression” which was “resistant to pharmacotherapy” (p.2). The report did acknowledge that ECT was highly controversial and that it often had negative side effects. In Victoria, Australia in 1998-99 approximately 40 persons per 100,000 resident population were administered ECT. Seventy-five percent of these had depression, and women over 64 years were most likely to receive ECT (Wood & Burgess, 2003). Another Australian study (Koopowitz, Chur-Hansen, Reid, & Blashki, 2003) reported on interviews with eight patients who had experienced ECT. All the patients expressed a fear of “brain-damage”, “memory loss”, and “damage to cognitive function” (p.51). However, they felt it had “done them good” and that it should be available to people as a voluntary treatment option (p.52). Paus and Barrett (2004) note that ECT may be used with the 30% of patients whose depression does not respond to drug treatment, and that it is relatively safe but requires general anaesthesia, muscular relaxation and induction of a seizure, and involves side effects such as “memory disturbances” (p.268). They discuss a less invasive treatment, transcranial magnetic stimulation (TMS) of the frontal cortex, and report that it has the potential to alleviate symptoms in the same way as ECT, but with less side effects.

Despite the many strong recommendations for medication, many people experiencing depression do not achieve recovery from the use of medication alone. A recent WHO Primary Care study found that 60% of people treated with antidepressants “still met criteria for depression after 1 year” (McPherson et al., 2005, p.332). With no great promise of cure and considering the risks involved and the possible side effects it is not surprising that many women choose to seek other treatment pathways. Talking therapies are the most commonly available alternative. The WHO study (McPherson et al., 2005) found that the most common response after discovering such “treatment resistance” was to offer a form of psychological therapy. Research about common forms of such therapy for depression, such as cognitive behavioural therapy (CBT) will now be reviewed.

### **Psychological therapies as pathways to recovery**

The most commonly recommended ‘talking cure’ for depression (e.g., Whitty & Gilbody, 2005) is cognitive behavioural therapy (CBT) which assumes a psychological

cause. Rupke, Blecke and Renfrow (2006) have described CBT as “a treatment process that helps patients correct false self-beliefs that lead to certain moods and behaviours. The fundamental principle behind cognitive therapy is that thought precedes a mood, and that both are interrelated with a person’s environment, physical reaction, and subsequent behaviour” (p.83). McPherson et al. (2005) studied the effectiveness of psychological therapies for “treatment resistant depression” by carrying out a systematic review. Of the twelve studies they reviewed all but one involved CBT, the other used psycho-education. The review concluded that even when depression had been unresponsive to medication psychological interventions demonstrated “some improvement” (p.338).

In another review Spencer and Nashelsky (2005) concluded that psychological treatment and ADM were equally beneficial for “adult patients with mild to moderate depression” and that there was limited evidence that CBT specifically was as effective as ADM for “patients with severe depression” (p.2309). Ward et al. (2000) compared 12 sessions of non-directive counselling or CBT with normal GP care and found both forms of counselling were equally effective for patients with depression, and both were more effective than normal GP care. Chilvers et al. (2001) compared ADM with generic counselling for treatment of major depression and found that the counselling was as effective as the medication. An interesting aspect of this study was that the model of counselling was not specified, but the condition was that six sessions of counselling were given by “experienced counsellors, who adopted the counselling approach they believed to be the most suitable” (p. 773). The conclusions of all three studies just discussed are in keeping with other findings that the specific techniques of counselling are not as relevant to effectiveness as the quality of the therapeutic relationship (e.g. Roth & Parry, 1997; Seligman, 1995). The recommendations for CBT may be more related to the ability to offer this form of counselling in a prescribed form and thus to carry out standardised trials of its effectiveness.

CBT also has limitations similar to those of the bio-medical model. It depends upon the analysis of an expert therapist who identifies ‘faulty thinking’ in the ‘patient’ and then works with them to correct it. The assumption is that there is something wrong with the individual that needs to be fixed.

The effectiveness of counselling for specific groups of women experiencing depression has also been studied. Spinelli and Endicott (2003) compared interpersonal psychotherapy with parenting education for depressed pregnant women, and found the

psychotherapy was significantly more effective. Gilliam and Cottone (2005) reviewed randomised clinical trials comparing couple therapy and individual therapy for depression and concluded that couple therapy needed to be depression specific to be effective, and that it was only relevant when there was evidence of relational problems. There would also need to be careful monitoring for violence and abuse within the relationship before couple therapy was advised.

Measuring the effectiveness of psychological therapy is complex and difficult. Levitt, Korman and Angus (2000) approached this issue in an innovative way, using clients' choice of metaphors of burden as a marker of recovery. As recovery advanced "metaphors of 'being burdened' were transformed into metaphors of 'unloading the burden'" (p.23). Therapy, however, is not always helpful or benign. Feminists have argued that therapy has the "potential for malignancy" (Rossiter, 1998) especially in public practice and "settings that are close to state power and social control" (p.10). An example of this would be where an emphasis was placed on curing depression in the individual through challenging negative thinking, whilst ignoring the context of abuse and disempowerment within which the depression had developed.

In guidelines for treatment of depression, such as those produced for New Zealand practitioners, (National Health Committee, 1996) the recommendations have often been for a combination of psychological and bio-medical treatment.

### **Combinations of professional treatments**

In this review so far the complexity of the experience of depression has been apparent. However, in professional literature this is often ignored. Thus when Fava and Ruini (2005) asked, in the title to their journal article, "What is the optimal treatment of mood and anxiety disorders?" (p.92) the only treatments considered were pharmacotherapy and psychotherapy, and their question was whether these should be administered sequentially or together. A meta-analysis (Pampallona, Bollini, Tibaldi, Kupelnik, & Munizza, 2004) had shown that combining these two forms of treatment was associated with a higher improvement rate than drugs alone. Fava and Ruini concluded that there are advantages in treating major depression initially with ADM, achieving rapid remission of symptoms, and then following through with psychotherapy. In contrast to the work just reported, Highet and Drummond (2004) compared different community treatments for post-partum depression, and found that psychological and pharmacological interventions were equally effective but that combining the two added

no clinical benefit immediately or after 6 months. A common recommendation has been for a greater emphasis on medication the more severe the depression (National Health Committee, 1996) and for talking therapy on its own to only be recommended for dysthymia or mild depression.

There are many barriers to women seeking and/or accepting professionally administered treatments for depression, some of which will be discussed later in this chapter. Next, I will discuss paths women follow which are drawn from stories outside the mainstream of medicine, psychiatry and psychology.

## **Pathways outside the mainstream**

### ***Complementary therapies***

I use the term ‘complementary therapies’ to cover a range of responses that women might try to relieve or manage depression. The term is used by Collinge (2005) and by Ernst (2003) who summarised 34 systematic reviews of complementary medicine which included herbal medicines, acupuncture, homeopathy and manual therapies. Collinge and his colleagues explored the integration of complementary therapies into a community mental health practice. The therapies they involved were massage, acupuncture, Reiki and Healing Touch, and all were used in association with psychotherapy. Both studies comment on how “complementary or alternative medicine has moved from the fringe of health care towards its centre” (Ernst, 2003, p.630) and that such therapies are “used by two thirds of Americans” (Collinge, Wentworth, & Sabo, 2005, p.570). Published literature about complementary medicine and depression comes from the USA and the UK and it is likely that similar use of therapies occurs in New Zealand. The research suggested that female, affluent, middle-aged, well-educated people are the predominant users of these therapies (Ernst, 2003, p.630) and that “mental health-related issues are among the most common reasons that people seek complementary therapies” (Collinge, Wentworth, & Sabo, 2005, p.570).

Depression is significant amongst the mental health issues for which people seek complementary therapies. A qualitative review of complementary therapies (Ernst, Rand, & Stevinson, 1998) concluded that exercise and St John’s Wort are both effective in treating the symptoms of mild to moderate depression (p.1026). Acupuncture, massage and relaxation were also found to be promising treatments. These may be of special value to vulnerable groups such as pregnant women, and a recent study has reported the value of massage therapy for pregnant women. Many

women try St John's Wort because of the range of adverse drug reactions associated with more conventional therapies and Stevinson and Ernst (1999) found that St John's Wort was "at least as safe, and possibly more safe than, all the conventional antidepressants" that they examined (p.131).

Ernst and Schmidt (2004) followed up internet web site recommendations for 'alternative' cures for depression. They assessed the 'harmfulness' of the recommendations, and found them "highly variable" (p.298). An interesting secondary aspect of this research was the summary of types of 'alternative' cures recommended. Botanical therapies dominated but amongst nearly 150 treatments there were also relaxation, exercise, art therapy, journaling and dance. The list also included some readily available foods, such as banana, oats and potato. This study indicates the complexity of studying 'alternative' responses to depression.

It is difficult to assess the effectiveness of such a range of recovery options, but Collinge et al. (2005) investigated the effectiveness of psychotherapy combined with complementary therapies for clients of a community mental health centre. Clients chose the therapy they thought best suited them from massage, acupuncture, Reiki, and Healing Touch and reported "high levels of satisfaction with the service and significant levels of perceived (self-rated) change in their mental health" (p.569). Clinicians reported that the five complementary therapy sessions enhanced the psychotherapeutic outcomes. Twenty of the 25 participants were women, all of whom had histories that included trauma, and nine had diagnoses of major depression. The study suggests integrating complementary therapy with psychotherapy would be of benefit. As well as using the internet, women seek help through books and there are a wide range of these available. Aspects of self-help will now be discussed.

### ***Self-help***

Self-help books related to mental health have been available for many decades (Papworth, 2006). Recently in Britain there has been economic pressure to promote self-help as "a method of alleviating distress caused by mental health problems" (Richardson & Richards, 2006). Guidelines for the treatment of mild depression have recommended self-help techniques, an approach that Richardson and Richards see as underpinned by the "principles of involving service users in the delivery of care and of accessibility to services" (p.13). Guidelines and programmes are available through the internet, libraries, bookshops and by post making them accessible to many who might

face financial or practical barriers to using psychotherapy and counselling services (Papworth, 2006). Unfortunately, however, self-help is not always effective. Richardson and Richards (2006) studied CBT based self-help, and found it was less effective than CBT offered through a personal therapeutic encounter. They suggested that the relational aspect of CBT may be significant in its demonstrated success. In contrast, Jorm and Griffiths (2005) focussed on this relatively inexpensive treatment in their recommendation that self-help strategies be advised for Australians experiencing sub-clinical depression and anxiety. This would free up more expensive services for those with more serious diagnoses such as major depression, and might prevent the development of some of these 'disorders'. They reported that there is evidence for the effectiveness of guided self-help strategies such as self-help books. A recent review of the effectiveness of self-help books based on CBT (L. Anderson, Lewis, & Araya, 2005) supported this view, finding that use of such books could relieve depression in some patients. In contrast, a randomized trial comparing the efficacy of self-help materials in addition to standard general practice treatment, with standard treatment alone (Salkovskis, Rimes, Stephenson, Sacks, & Scott, 2006) found no identifiable improved outcomes in depression scores. They did find, however, that both general practitioners and patients were highly satisfied with the increased knowledge gained through the self-help "Care Partners" package and its suggested strategies.

One way of gaining the economic benefits of self-help but also involving depressed women in relationship may be by combining self-help and support groups.

### ***Social support and group involvement***

Professionally guided self-help groups were part of a project on women and depression in Finland (Laitinen, Ettorre, & Sutton, 2006). The groups assisted women to understand themselves and "believe in their potential as social individuals" (p. 306). The women found that groups helped them to accept, manage or heal their depression. Attendance at groups may combat a sense of aloneness which is often part of depression. A study of older women being treated for depression (Pierce, Wilkinson, & Anderson, 2003) acknowledged that in present day Western society being old, without a spouse and living in a one-person household can be seen as a sign of "social failure" (p.21). Women who overcame this sense and understood aloneness not as loneliness but as a symbol of "independence and autonomy" became less depressed. They could then choose to be part of groups or to enjoy their own company. A New Zealand study of the

benefits of an activity group for older women with late-life depression (McWha, Pachana, & Alpass, 2003) also supported the value of groups. Conversation was the activity considered to be “most enjoyable and important” by group members (p.168).

Severely mentally ill women can also benefit from group work. A group which blended feminist principles and psychiatric knowledge (Avery, 1998) allowed women to receive specialised support for their distress related to “severe and persistent mental illness” (p.2), whilst still recognising the impact of society’s oppression of women. The group developed a number of goals, including “personal sharing” and discussion of “ideas about women’s oppression” (p.6). As well as discussion the group worked together to create a mural which they called ‘Women Connecting’.

Twelve step groups are a special form of support group. For women experiencing depression they are offered through GROW which Julian Rappaport (2000) described as a “mutual help group” which “explicitly challenges the dominant cultural narrative behind both professional and lay expectations for mental health” (p.14). He explained that the members see themselves as “forming a community and writing their own narrative, complete with their own mythology and heroes to believe in” (p.14). Any person who identifies as being a former or current mental patient can be part of GROW. A survey in the USA, however, found that professionals were reluctant to utilize such mutual support groups (Chinman, Kloos, O’Connell, & Davidson, 2002) in spite of evidence that they can be beneficial. The authors of the survey suggest that “professional-centrism” or “professional preciousness” may be a reason for the lack of referral (p.353). The benefits of groups are sometimes combined with exercise such as walking to offer companionship and to ease symptoms of depression (Dimeo, Bauer, Varahram, Proest, & Halter, 2001). Pathways to recovery involving exercise and nutrition are other alternatives to standard therapies.

### ***Physical exercise and nutrition***

Regular physical exercise can have a positive effect on mood (e.g. Berger & Owen, 1992 ; Joiner & Tickle, 1998). In part this may be due to bio-chemical changes (Dimeo, Bauer, Varahram, Proest, & Halter, 2001), but psychological changes also occur. A review by Chrisler and Lamont (2002) concluded that when women exercise they may not only reduce their symptoms of depression, but also “raise self-esteem and self-efficacy” (p. 9). The authors believe that feminist therapists should encourage depressed female clients to take part in physical exercise because it can help to



empower women to “stand out boldly and confidently in order to meet their own needs and to demand social and political changes that would make it easier for all women to define themselves” (p. 11). In a more rigorous study Van de Vliet et al. (2003) found that attending multi-disciplinary treatment, including physical activity brought about significant improvements in depression, self-esteem and physical self-worth. The participants in their study were 51 female patients in a psychiatric hospital in Belgium, all of whom had a diagnosis of major depression. The physical activity involved both leisure time supervision once a week, and fitness training three times a week. As well as the benefits for mental health, the women showed improved strength, muscle development and pride, respect and confidence in their physical selves.

Bodnar and Wisner (2005) reviewed published research concerning poor nutrition as a risk factor for depression and concluded that there was an association between depression and specific deficiencies linked with inadequate diet. They recommended more research about nutritional factors in mental health, especially for women of child-bearing age because “nutrition interventions can be inexpensive, safe, easy to administer, and generally acceptable to patients” (p.679). Changes of diet and exercise are amongst the things that women may do to help themselves without using any professional help.

Women need to value themselves before they will take the initiative to seek help, and this may not happen because depression can involve a devaluing or silencing of the self (Jack, 1991). Also women may not trust professionals to understand their situation or to listen to them sensitively. This is a complex issue, and the central topic of this thesis, but in this literature review it needs to be mentioned before I reflect on work about women managing their depression without mainstream professional help.

### ***Coping without help***

Some women choose to cope with depression without professional help, others are unable to access such help. Yvette Scattolon (1999, 2003) explored how women living in rural communities in Canada coped with the feelings of distress “unaided by professional help” (Scattolon & Stoppard, 1999, p.205). The 15 women who were interviewed identified themselves as depressed, and “had not sought professional help for their distress” (p.206). Their experience of depression was one of “isolation and aloneness” and it was a “private” emotional experience, “not shared with others” (Scattolon, 2003, p.164). The women seemed to talk from an unspoken set of

assumptions about “how women should behave as wives and mothers” (Scattolon & Stoppard, 1999, p.209). The expectation was that they should take responsibility for the home and the needs of all family members, even when this resulted in them denying their own needs. Neglecting “feminine practices” of maintaining a “youthful look” was experienced as very distressing, as was the difficulty they experienced in carrying on with “many aspects of their lives as mothers and wives” (p.210). The women coped with their depressive experiences, which they had often normalized, by getting on with life, seeking support of friends, family or “strangers who had similar life experiences” (Scattolon, 2003, p.175) or by withdrawing which was sometimes a positive experience of “sanctuary” (p.177).

One of the women in Scattolon’s (2003) study chose not to seek help from her doctor for her depressed feelings because she did not want to expose herself. This is one reason why women do not seek professional help. Some possible explanations of rejection of professional help, or failure to seek such assistance will now be discussed.

### **Help-seeking and barriers to receiving help**

In the late 20<sup>th</sup> century, in the Western world, including New Zealand there were strong messages about where to seek help for depression. The messages came from the powerful stories of the professions, particularly medicine and psychology. Within New Zealand this message was exemplified by the guidelines distributed to all counsellors, psychologists and general practitioners (GPs) in 1996 (National Health Committee, 1996). They included a leaflet ‘Coping with depression’ to be handed to anyone experiencing depression. In bold letters on the cover is the statement “If you are experiencing depression, it is important that you see a professional (doctor, nurse or counsellor) for help.” Messages sponsored by drug companies were even more medically oriented. For example the company which manufactured and marketed Prozac, Eli Lilly, included in their leaflet entitled ‘Depression: The Road to Recovery), the following statement:

Depression is not something that you brought on yourself, and it does not reflect a personal weakness or an inability to cope. Rather, clinical depression, like diabetes and thyroid disease, is believed to be caused by a chemical imbalance. The imbalance that leads to depression involves chemicals in the brain called neurotransmitters or chemical messengers that are believed to be important in regulating mood. Depression occurs when the brain’s availability of these messengers is disturbed.

(Eli Lilly & Company (NZ) Ltd., 1996, p.6)

International literature suggests, however, that many people do resist these powerful, authoritative messages and choose not to seek professional help for depression. In so doing many are rejecting the call to the medicalisation of their lives. A Norwegian study (Roness, Mykletun, & Dahl, 2005) found that only 13% of people suffering from depression had sought help (p.51). A Canadian study of young people aged 15 to 24 years found that only 25% of those with mental health problems sought help (Bergeron, Poirier, Fournier, Roberge, & Barrette, 2005). Both studies asked the participants whether they had experienced symptoms associated with mental health problems, so they had not necessarily had a professional diagnosis.

A Canadian study (Wang et al., 2005) analysed responses of the 1563 respondents diagnosed with major depressive disorder. They had been in contact with professionals in order to have a diagnosis, yet only 52.9% of them reported having used some type of help during the year of the study and for 21% this help was a “natural health product” (p.652).

Many reasons have been suggested for the reluctance to seek help from professionals. Stigma is a common one, often seen as a barrier to professional help-seeking for depression (e.g. Cooper-Patrick et al., 1997; Hoyt, Conger, Valde, & Weihs, 1997; McNair, Highet, Hickie, & Davenport, 2002). Barney et al. studied stigma about depression and its impact on help-seeking intentions (Barney, Griffiths, Jorm, & Christensen, 2005). The respondents to their postal questionnaire were 1312 Australian adults. The study explored both ‘self-stigma’ or embarrassment and ‘perceived stigma’ or expected ‘condescension’ from others. Both these prevented many people from considering seeking help, and although the differences were small, the embarrassment was reported as strongest when they considered seeing a psychiatrist (44%) less so for counsellors (34%) and for complementary practitioners (32%) and least for GPs (29%). The greatest “condescension” was expected from GPs (20%), then from psychiatrists and complementary practitioners (17%) and least from counsellors (16%). As was recognised in the study just discussed, people acknowledging a possible need for help have to decide who to approach, and they also need to weigh up the negative aspects of help-seeking. Availability of services is a very significant barrier for many people, and this may include issues of time, finance, transport and child-care.

A German study (Riedel-Heller, Matschinger, & Angermeyer, 2005) explored “what sources of help and treatment options Germany’s lay public prefers in the case of

mental disorder” (p.167). They focussed on schizophrenia and major depressive disorder, presenting vignettes representing each. Respondents were asked to label the problem and then choose a preferred source of help, representing mainstream professionals, complementary therapies and lay support. The options were: “confidant, psychiatrist, psychotherapist, family physician, self-help group, priest, community nurse/district or community public health department, non-medical practitioner, cure at a spa” (p.168). When the symptoms were seen as depression the participants preferred to seek help first from psychotherapists (22.4%), psychiatrists (21.2%) or a family physician (20.1%). Almost 17% had a confidant as first choice, and 11.2% a self-help group. This is in contrast with the responses to the scenario of schizophrenia. In that case 34.6% had a psychiatrist as the first choice source of help. When they saw the cause as biological they were less likely to suggest seeking help from the “lay support system” (Riedel-Heller, Matschinger, & Angermeyer, 2005, p.170) and when they perceived that psychosocial stressors were the cause of distress a “confidant was more likely to be mentioned as the first source of help” (p.170). This study suggests very clear connections between the commonly available and accepted stories about causes of mental health problems and the choices people make about whom to go to for help.

People are not always aware of the influential factors involved in their choices. Advertising, for example, often reflects the powerful messages of the professions, and consumers may be unaware of these forces. Chananie (2005) explored the strategies that pharmaceutical companies use in Direct-to-Consumer advertising. The audience were potential consumers, “especially women, who were experiencing emotionally symptomatic “disorders” including depression, premenstrual syndrome and menopause” (p.487). The advertising strategies identified in the study included “establishing medical legitimacy, blaming and shaming, using feminist and 12-step movement rhetoric, and offering validation and empowerment to women” (p.487). Chananie suggests that by offering women the opportunity to use medication to control their “disordered” lives they are constructing and maintaining “cultural beliefs in the omnipotence of the quick medical solution to what can be ‘ordinary’ experiences or social problems” (p.488). They reinforce the medicalizing of women’s natural bodily processes and emotions and support the valuing of “hegemonic ‘masculine’ standards of emotional behaviour, such as aloofness, aggressiveness, and competitiveness” (p.514). Frankenberger et al. (2004) supported this view in a study of the impact of pharmaceutical companies’ advertisements on college students’ perceptions of

antidepressant medication. They compared the impact of scientific information and pharmaceutical advertising on college students' decisions about depression and its treatment. Forty percent of female students who had read the advertising rated themselves as having depression, compared with only 6% who had read the scientific information. The women in the advertisement condition were also significantly more likely to believe that depression required treatment with medication and to recommend this treatment to others.

Similar issues have been explored by Gammell and Stoppard (Gammell & Stoppard, 1999; Stoppard & Gammell, 2003) who interviewed women who had experience of being diagnosed and treated for depression. All nine of the women in their study had been prescribed antidepressants and only one had chosen not to take the drugs. This is not a free choice for women. Stoppard and Gammell noted that treatment options for women were often limited to medical and psychiatric services and that feminist therapy was frequently either unavailable or unaffordable. This situation also exists in New Zealand. Ten years ago I explored what GPs offered women who had symptoms of depression (Wilson, 1997; Wilson & Read, 2001), and found that whilst they valued biological, psychological and often social responses and support they felt restricted to prescribing antidepressant medication because of the high cost and limited availability of their preferred options.

The final issue I will discuss in this section concerns 'non-compliance' with advice to take antidepressant medication. Demyttenaere (2001) concluded that approximately 35% of primary care patients discontinue antidepressant medication in the first month. The so-called side effects account for 18% of this non-compliance. These adverse drug reactions are many. When patients were interviewed about the impact of antidepressant medication on their lives (Garfield, Francis, & Smith, 2004) they were able to cope with the "minor" reactions of "mild nausea, constipation, dry mouth, dry skin, minor headaches, sweating and loss of appetite". The adverse reactions that they found more concerning were "more severe nausea, tiredness, lethargy, insomnia, difficulties with sexual relationship, dizziness, pulling sensations, weight gain, blurred vision and wheezing" (p.243). It is not surprising that many women would seek recovery paths which do not involve these effects.

Women who are reluctant to seek or to accept professional help do not, however, need to live with depression. There are many things which can happen to reduce or eliminate depressive symptoms from women's lives, some are deliberate and

others may be happenstance. Research about some of these changes will now be reviewed.

### **Changes in women's lives**

Brown, Harris and their colleagues in London have made a major contribution to an understanding of depression and its relationship with the ongoing difficulties faced by women, including the stresses associated with inadequate housing, poor financial circumstances and child care responsibilities (G. W. Brown & Harris, 1978). They introduced the idea of 'fresh start' events as occurrences which often preceded "the recovery or improvement of women ... suffering from chronic depression" (G. W. Brown, Adler, & Bifulco, 1988, p.487). In a three year study of "largely working-class women with a child living at home", 49 experienced chronic depression, 26 of whom recovered (p.488). Of these, half had received medication or psychological or social work treatment. When they explored the three months in the women's lives prior to recovery they found that most had experienced what they called a "fresh start event" (p.490). This term was used for events which did not seem to reduce any specific difficulty, but "did mean an important change in the subject's life and one that appeared to herald a new hope – an indication that there might be a new way forward". Examples given were "moving from a flat to a house with a garden, finding a new friend" (p.490). In earlier studies they had found that social support which was "known to be available" (G. W. Brown, Adler, & Bifulco, 1988, p.491) was related to recovery, as was the reduction of difficulties such as being able to pay off serious rent arrears because of new employment (p.490). In the 1988 study 69% of women who recovered from chronic depression had experienced either a reduction in difficulty, or a fresh start event.

A feature of the 1988 study (G. W. Brown, Adler, & Bifulco, 1988) which has particular relevance to this thesis is that many of the women who recovered seemed able to take agency and make decisions about the course of their lives. The paper includes a case study of a woman who recovered after she managed a housing change. After trying unsuccessfully for years to move to a different council house away from a persistently noisy neighbour she deliberately became pregnant to qualify for different housing. She moved and almost immediately recovered. Other stories indicate the complexity of the recovery journey, and the importance of the meaning that each woman makes of events.

In work published in 1992 (G. W. Brown, Lemyre, & Bifulco, 1992) the ‘dimension’ of ‘fresh start’ was extended to include an ‘anchoring’ dimension which involved “increased security” and a ‘relief’ dimension which involved the “amelioration of a difficulty”. They found that recovery or improvement was more likely to be associated with anchoring and fresh start events than with relief (pp. 51-52). The emphasis on women’s meaning-making and on the situated nature of their depression is valuable. Busfield (1996) critiqued this body of work, and acknowledged that although it considers the “situational features of individual’s lives” it “takes the structural arrangements and culture of the society as given” (p.198). There is little emphasis placed on the gendered nature of poverty, the difficulties that women face when they become single parents, or the political decisions involved in housing provision.

The significance of fresh starts is also reflected in a New Zealand case reported by a General Practitioner. Woolford (1990) saw a 25 year old Māori woman whom he described as having a “major depressive disorder”, a history of sexual abuse, alcohol and marijuana abuse. She had made several serious suicide attempts. She felt there was “no way out of the black hole which was herself and her life” (p. 129). Woolford believed there was “every indication to start her on antidepressant medication”, but hesitated. The treatment he decided on was multi-faceted. He put her onto a sickness benefit, referred her to a Māori health unit, where she helped at the kohanga reo (pre-school conducted in Māori language) and began to learn her language. She attended an alcohol programme for Māori, run by Māori and visited him regularly to monitor her programme. Woolford, the medical expert, proposed and managed this recovery journey but took account of personal and cultural needs. Woolford reported that she made rapid and dramatic progress and attained “serenity and composure” in her life as a “contented, sparkly, competent mother” (p.130). This doctor, who identifies as Pākehā, acknowledged the relevance and wisdom of Māori healing which he notes has “always revolved around the three basic tents of Tinana (the body), Wairua (the spirit) and Hinengaro (the mind)”. He might have added Whanau (the family and kin). Woolford concluded his paper with the statement “Māoritanga gave her back strength, hope and her personhood.” This work could have fitted with the ‘fresh start’ description of Brown and his associates. It is also a reflection of the possibilities of work involving Mason Durie’s approach to the self which I presented in Chapter One.

I will conclude this review with research which foregrounds women's knowledge. These stories do not fit into any single category because they are holistic and embodied.

### **Women's recovery stories**

In their conclusion to a collected volume of research which draws on and respects the knowledge of women who have experienced depression, McMullen and Stoppard (2003) emphasise the value of hearing the "voices of many women". In this final part of the literature review I will review research projects drawing on women's knowledge and their narratives of recovery from depression.

Melva Steen (1995) interviewed 22 women about the meaning of their experience of recovery from depression. She considered the possibility that depression might be a way in which a woman "withdraws to conserve her energy", a method of coping with life (p.77). She uncovered five phases of recovery with the third phase being one where women became aware that they needed help for their depression, but she explains that during this trial and error period "many women were subjected to patriarchal standards and made to feel as if the illness was their fault" (Steen, 1995, p.79). The fourth phase was when the women "began to take charge of their own recovery process" and to trust their own ability to know what was helpful and unhelpful for them. The final stage saw them living "fuller, more satisfying lives" and feeling "hopeful for the future" (p.79). Steen did not deliberately seek women who had rejected professional treatment. Nevertheless, many of the women in her study found the experts who tried to treat them "patriarchal", "punitive" and "insensitive to the needs of women" (p.83). The women began their recovery when they became "agentic" and actively participated in their treatment. Part of becoming actively involved was realising that the "experts were fallible" (p.85). Steen uses the vivid metaphor of "becoming a gardener" to name the final stage she uncovered; a stage when women began to "cultivate the self" (p.87). They weeded out old ideas planted some new ones, and found "new ideas of how to be a woman in today's world".

Steen concluded (1995) that the medical model, with its focus on illness, not health, encourages women's dependency on the expert, and that this is not helpful for women experiencing depression. She also considered that the women may have used depression as one of the few legitimate ways of getting what they need, which may



have been time to rest, to have a break from stressors, space to make decisions, a break from caretaking and time to have their own nurturing needs met.

Rita Schreiber's understanding of the causes of depression has already been reviewed. In four articles published between 1996 and 2001 she talked with many women about their experiences of depression and recovery (Schreiber, 1996a, 1996b, 1998, 2001). In 1996 she summarised the "basic psychological process of women's recovery from depression" as "(re)defining the self" (Schreiber, 1996a), but stressed that this redefinition took place "within a complex network of social interactions" (p.165). The stages uncovered within this process were described as "seeing the abyss" when the woman confronts her depression; "telling my story" and "seeking understanding" when women disclose their life situation; "clueing in" when "the woman's consciousness about her self and her world changed, often quite suddenly" (Schreiber, 1996a, p.484) and "seeing with clarity" when women could look back and reflect on their journey and "appreciate" where they were now (p.486). In 2001 Schreiber reviewed a number of different studies, and focussed on the process she named "wandering in the dark" (Schreiber, 2001). She concluded that "acknowledging vulnerability and other disowned parts of self is a key point in recovery, as it challenges the previously internalized societal expectation for women to be strong and productive" (p.96). The theory is situated in a landscape where in the best situations women become able to "challenge the hegemonic power relationship between the sexes" although most of the women she interviewed created a personal recovery which precluded "political action" (p.96).

A Swedish study of 13 women who had been hospitalised with major depression explored the way that they coped with depression in their daily lives (Skaersaeter, Dencker, & Bergbom, 2003). The four categories that they identified as part of the coping process were 'self-healing', 'managing', 'receiving social support' and 'finding meaning'. The women went through a recovery process which involved both "cognitive" and "emotional" understanding (p.420), and they found that they needed both professional and lay support. For these women receiving a diagnosis imparted security and a "feeling of not being alone" (p.426). However, they did not just accept professional advice; they wanted to "be treated on the basis of their living in a social context" (p.427) and be given a wide range of treatment options. Part of their managing process involved being "empowered" which had some similarity to Schreiber's "clueing in". The people who supported the process were both health

professionals and friends, and they also used ‘complementary’ cures such as “exercise, positive affirmation, hypnosis, music, reading, painting, and vitamins and minerals” (p.427). Finally these women reflected over their lives and as they recovered they came to believe in the future, finding meaning in their lives.

Vidler (2005) sought the beliefs of 22 women who had experienced depression regarding what they believed contributed to their recovery. Again, the process that emerged was complex, but as with the studies already reviewed, the women knew that their recovery involved their social context, and they wished to be included in decisions about treatment.

In a New Zealand study, Marie Crowe (2002) used discourse analysis to explore the narratives of 12 women hospitalised with depression. She commented that “the distress of their situation and experience is not fully represented by the label depression” (p.127). Implications for women of the contemporary western focus on “reflexivity and detachment” (p.127) were explored, leading to a suggestion that in contrast to this focus women’s most available subject position requires them to demonstrate nurturance and a focus on others. The resulting tension may leave women vulnerable to “experiencing depressive responses” (p.129), including bodily symptoms of “agitation, sleeplessness, loss of appetite and fatigue” and the loss of a “meaningful and organised sense of self” which may lead on to a “desire to remove oneself from existence” (p.130). Crowe suggested that for many women in this situation the “nothingness of death and the meaninglessness of life may become merged” and that the more there is a focus on “reflexivity and detachment” the more the women experience “terror” as the meaning of their life unravels (p.130). She believed the implications of this analysis for mental health practice and treatment were that effective therapy would have to involve such responses as assisting individuals to “establish new significance and meaning in their lives” by “accepting difference and promoting multiplicity in individual’s response to their social world” and “promoting social responsibility and communality and connection with others as a form of resistance to detachment and reflexivity” (p.131).

These studies present a complex, at times contradictory, contextualised and embodied understanding of women’s journeys of recovery from depression. I will now consider where further research may be needed and where my research fits.

### ***Need for further research and the place of this project***

The studies reviewed, especially those in the final section, reveal a number of possible pathways to recovery. They raise the possibility that depression may serve a legitimate purpose for women, allowing them to withdraw from stressful and unsatisfactory experiences of life. There is a repeated theme of the importance of women taking an active part in the planning and process of their recovery, and not depending on experts, especially those who do not listen carefully to the women in distress. The fallibility of professional experts is raised. Perhaps most important of all there is a suggestion that women need to move towards the discovery of meaning in their lives, perhaps through self-awareness and certainly with a consideration of the social context in which their depression has developed.

I am interested in the ways that women recover without expert help, and the knowledge that they may have available to share when they have taken this journey. Scattolon's research comes closest to the work I planned, but the Canadian women she talked with were coping without the help of experts because that help was not available, or because they felt restrained from asking for support. The women in my research are urban women, who had mainstream professional help available but chose either not to use it, or to supplement it with 'complementary' solutions.

A number of studies that I have reviewed discovered women wish to be more pro-active and involved in their treatment, and I hope that my research will add to our understanding of how women come to take control of their recovery, and some of things they have discovered from having their own agency during this process.

In the next chapter I will discuss the narrative approach to research which I selected as the best fit with my research question.

## Chapter Four: We Are The Stories We Tell

*The basic principle of narrative psychology is that individuals understand themselves through the medium of language, through talking and writing, and it is through these processes that individuals are constantly engaged in the process of creating themselves. The focus on meaning and interpretation is of extreme importance. It is a focus which distinguishes narrative psychology from more traditional psychological approaches and also highlights the inadequacy of quantitative, 'scientific' methods for the study of self and identity.*  
Crossley (2000, p.10)

In this chapter I explain why I chose narrative inquiry as the most appropriate research approach for this project. I will introduce the particular ideas which underpin this approach, building on ideas presented in the preceding three chapters. I will then discuss the specific kinds of analysis I have used to explore different aspects of the data I have collected. I have presented these ideas separately from the method described in Chapter Five because they form a link between the ideas underpinning the project and the practice of the research.

The title of this chapter comes from the introduction to *Identity and Story: Creating Self in Narrative* (McAdams, Josselson, & Lieblich, 2006, p.3), edited and contributed to by some of the people whose writing has influenced my research approach. The narrative theoretical approach which informs this thesis is more than Sarbin's idea that narrative is the "organising principle for human action" (1986, p.9). The ideas which resonate with my experience are those of Bruner (2002), Crossley (2000), Gergen (2000) and Polkinghorne (1988) who advocate that personal narratives construct people's identities. Bruner (2002) wrote:

We constantly construct and reconstruct our selves to meet the needs of the situations we encounter, and we do so with the guidance of our memories of the past and our hopes and fears for the future. Telling oneself about oneself is like making up a story about who and what we are, what's happened, and why we're doing what we're doing. (p.64)

### ***Narrative research overview***

In the past quarter of a century, while theorists and narrative therapists have developed ideas of the socially constructed self, there has been a parallel development of research approaches based on social construction, narrative ideas and a relational understanding of the self. Robert Neimeyer (2000, p.215) wrote of the "self as tenuously anchored in a shifting sea of relationships" when he presented an alternative ontological argument to

that of the dominant views of the self in much of psychology and sociology. He argued for a self that is situated dialogically.

The dialogical self is embodied and is also contextualised. The body, dialogue and context can all be encompassed within a narrative understanding, and they can be explored through narrative research. The dialogical self is created within a context. Hesook explained narratives as “stories of individuals etched within the communal stories of the time and context” (Hesook, 1999, p.37), an understanding that is consistent with Frank’s ideas of narrative habitus discussed earlier (2002a).

Catherine Riessman (1993) has written of how she was guided by Elliot Mishler (1986) to think of interviews as narrative. Riessman discussed her own life involvement in inquiry across traditional academic boundaries, including studying literature, drawing ideas from gender politics and from critical texts in anthropology and philosophy as well as holding a chair in sociology and social work. She wrote of her “multidisciplinary identifications” (1993, p.vii). Such a generic approach is common amongst narrative researchers and theory makers, and I find it more valuable to my topic than any purely psychological form of research inquiry.

Definitions of ‘narrative’ are many. One explanation that is compatible with my approach is proposed by Hurwitz, Greenhalgh and Skultans (2004); “Polymorphous in content, malleable in form and dynamic in expression, narratives are compositions of unfolding meanings which can be discerned and followed by an audience” (p.1). A simpler definition, taken from Webster’s dictionary is that narrative is a “discourse, or an example of it, designed to represent a connected succession of happenings” (Lieblich, Tuval-Mashiach, & Zilber, 1998, p.3). Both these definitions introduce the idea of sequence, and that is one feature that is important to my topic. I wanted to understand women’s experience of the *sequence* of happenings linked with depression seriously disrupting their lives, and then no longer having this major impact.

Narratives, like ‘self’ are also dialogical. They involve a teller and an audience and they take place within a context. Riessman (1993) discussed the need to attend not only to the historical context within which the story is told, but also to the “interview context” (p.31). The researcher can seek out the stories of particular groups of people who have lived the experience that is the focus of the research. In doing this they are setting the ‘topic’ much as an English teacher might set an essay topic. The story that is told, however, draws on the experience of each story-teller, and they tell it in relation to

a variety of conditions including, the historical time of telling, the cultural stories that are available to them, and the perceived audience, including the interviewer.

Consistent with social constructionist views, the story that forms the research data is not ‘truth’ in any absolute sense. Plunkett (2001) noted that narrative inquiry is a valuable way of exploring the “meaning created by the individual as she or he constructs it in a social context” (p.151). Riessman (1993) explained how narrative interpretation of women’s stories in a project about the lives of women activists “did not assume a correspondent relationship between what the women told and actual experience or behaviour”, rather the researcher “explored how women constructed their positions narratively” (p.26)”. Kirkman (1999) used a narrative inquiry approach to explore the stories of women who were unable to achieve motherhood. She assumed that “the account given by each woman is only one of a range of possible narratives she could have constructed. Nevertheless, it is a version which was significant to her and which she found acceptable at the period of the research” (p.3). This acknowledgement that narratives are historically situated also works well for my study of depression, where treatments that are readily available and/or acceptable have varied so much through the last half century.

I have argued in Chapter Two (pp.29–34) that depression is a socially constructed label for a variety of types of distress experiences. It is a readily available label in Western Society. Fee (2000) proposes that the “clinical syndrome” of depression is particularly available to become a part of “self-construction” and “self-definition” at this time in history (p.75). This has come about because the “languages of depression” are not confined to the experts of the mental health profession, but have become what Fee calls *social objects* with “personal and collective significance” (p.75). Depression is something that lots of people know about, and can incorporate into the stories they tell about themselves. Depression can be part of a “reflexive process of self-definition and identity construction” (p.75).

The narratives that form the data for this project were told by women who have incorporated ‘depression’ into their identities at times in their lives. They are intimately acquainted with a distress which fits with some of the available stories of depression. They also understand this as an experience which has severely disrupted their lives, but one from which they have now ‘recovered’. I would expect that the stories they tell from this position of recovery will offer some understanding of how they have changed their identity from being depressed to being ‘recovered’. I believe that a narrative

approach will offer a variety of ways to seek out some of the meanings within their talk and will help me towards an understanding of the ways they construct themselves through their stories. The analysis will of course be my interpretation of their stories.

Gregg (2006) has considered a range of approaches to the study of identity as it may be presented in life-story narratives. He critiqued approaches which he considered have tended to search “their data for relatively simple and *explicit* self-characterizations” (p.63), suggesting that a recognition of “meaningful ambiguity” and the valuing of symbols and abstract concepts, similar to the work of many “anthropologists and literary theorists” could enable the recognition of the multiple and sometimes conflicting nature of identity (p.64). He advocates a search for “abstract deep structure” in identity research (p.85). I sought depth and complexity by using a variety of approaches to the narratives I gathered, ranging from a ‘micro’ examination of some passages and their language, through to a ‘macro’ consideration of the common structural elements of the 18 narratives.

One of the strengths of narrative inquiry is that it enables the researcher to adapt their analysis to the understandings that are emerging from the thorough and repeated reading of the texts. Manning and Cullum-Swan (1994) wrote:

to a striking extent, narrative analysis is rather loosely formulated, almost intuitive, using terms defined by the analyst....Thus themes, principal metaphors, definitions of narrative, defining structures of stories (beginning, middle and end), and conclusions are often defined poetically and artistically and are quite context bound.... These approaches are little shaped by the traditions of content analysis or the coding used in quantitative sociological work (p.465).

During the process of analysis I have adopted a variety of approaches and some of those which I used only for small sections of the data will be explained within the six findings chapters. I will now briefly discuss each of the major approaches to narrative analysis that I have used.

### ***Narrative Analysis***

The data for my project consists of 18 interviews which when transcribed yielded nearly one thousand pages of data. Analysis had to be selective, but I also chose to portray complexity and to answer my research question as thoroughly as possible by using a variety of approaches to study and analyse the text. Lieblick, Tuval-Mashiach and Zilber (1998) reviewed different ways of “reading, interpreting, and analyzing ... narrative materials” and suggested that there were two dimensions involved: those of

“(a) *holistic versus categorical* approaches and (b) *content versus form*”. These categories were clearly differentiated at the “polar ends” but “many possibilities for reading a text represent middle points along these dimensions” (p.12). Tuval-Mashiach (2006) later proposed different kinds of mapping of “the narrator in the story realm, where *perpendicular mapping* refers to the themes and topics with which the narrator is engaged, and *horizontal mapping* refers to their change and development throughout life” (p.250). These ideas are consistent with the reasons why I chose to use a variety of different approaches in this project. Tuval-Mashiach examined more closely the value of considering these two kinds of mapping, pointing out that the teller is usually very aware of content, but awareness of “structure (of form)” may “touch on more unconscious and less manipulated levels of identity” (p.250).

All these attempts to simplify narratives are just that. The content, the themes, the structure all intertwine, but analysis requires that they be at least partially disentangled. These dimensions help the explanation of analytic methods I found appropriate.

### **A beginning, a middle and an end**

In its simplest form a narrative consists of a beginning, a middle and an end. These elements are seldom spoken in sequence with the teller intermingling different aspects of their recollected story. The researcher can analyse the transcribed text by identifying sections that belong in each part of this sequence. In modern times this breaking down of the text can be assisted by computer programmes such as Ethnograph (Manning & Cullum-Swan, 1994) or NVivo. Lapsley, Nikora and Black (2002) used NUD\*IST (Non-numerical unstructured data indexing) software to assist the analysis of their interview data related to recovery from serious mental ill health. Their interviews had been organized around three stages of problem, recovery and life after. From the analysis of the sequence of events that they heard in the stories there emerged eight stages: “origins, onset, the experience of mental ill health, consequences, three stages of recovery and life afterwards” (p.11).

Bruner (2002) includes another element in his discussion of features that turn a “routine sequence of events into a story” (p.5). The element is *peripeteia*, an idea from Aristotle, and it refers to a “sudden reversal of circumstances” (p.5). Bruner comments that “one rarely encounters autobiographies, whether written or spontaneously told in interview, that are without turning points” (p.83). Lapsley, Nikora and Black, in the

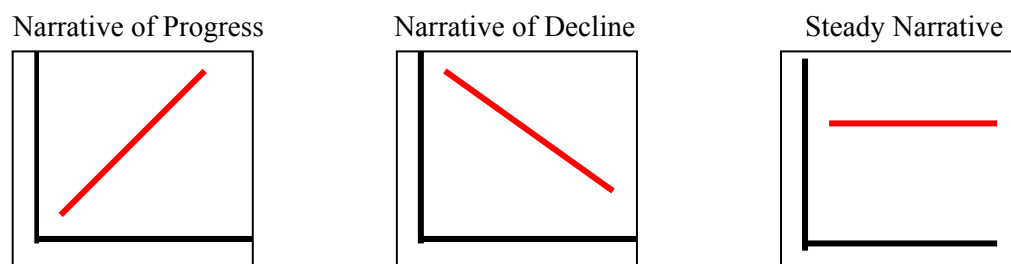


research just mentioned, found that “the most dramatic aspect of recovery narratives was the *turning point*, often a rapid event or sequence of events whereby people took charge of their situation, gained hope, developed insight and a new sense of direction” (p.45).

It seems likely that many narratives of women’s lives will involve these features: a beginning, a middle, and end, and possibly one or more turning points. Amongst the wide range of writing about narrative research there are some authors who have developed more detailed ways of describing the over all structure of narratives. Rivke Tuval-Mashiach (Lieblich, Tuval-Mashiach, & Zilber, 1998) uses graphs to explain some common structures.

### **Holistic analysis with graphs**

Tuval-Mashiach (Lieblich, Tuval-Mashiach, & Zilber, 1998) explored gender differences in the life narratives of adults. Her written analysis was accompanied by a series of graphs which represented the “course of development” of the narrator in terms of “thematic foci” such as “development of social skills, independence, gender identity” (p.91). She discerned three general patterns which she named: Narrative of Progress, Narrative of Decline and Steady Narrative” (p.90). These were represented as shown in Figure One.



**Figure One:** Representations of developmental structure (Lieblich, Tuval-Mashiach, & Zilber, 1998, p.90)

It is possible to represent other aspects of the form of a narrative in this graphical way, which enables the comparison of structures across a number of different people’s narratives. In the work of Tuval-Mashiach this enabled her to consider turning points and sequences of progress and decline, as well as different rates of development. She notes that there are many limitations to structural graphs, but considers that they are “an

effective tool for presenting large quantities of narrative material in a clear, visually accessible format” (p.103). I have used this style of representation in my analysis and will explain that in more detail in the next chapter.

Arthur Frank (1995) offers another way of reading and representing narratives in an holistic way. He developed a typology through his work on chronic illness. Although he focussed on physical illnesses more than mental ‘illnesses’ such as depression, his typology has informed some of my analysis and it will now be introduced.

### **Arthur Frank’s narrative typology**

Frank (1995) experienced cancer himself and this drew him to study illness stories, the “stories told *through* suffering bodies” (p.24). He heard many stories of suffering, “thought with them”, and heard “different nuances of potential meaning” as they were told in “different circumstances and at different ages” of life (p.24). He chose to place these stories in an analytic framework, which could “disentangle types of narratives” (p.24). This resulted in his descriptions of three types of illness narratives; restitution, chaos and quest. Frank emphasises that by suggesting three underlying narrative types he “does not deprecate the originality of the story any individual ill person tells” (p.76). Any person’s telling will “combine all three, each perpetually interrupting the other two”, but the typology can be used as “*listening devices*” (p.76). This is how I have used them.

The restitution narrative involves a wish to “be healthy again” and to “be restored to what society considers the “normal condition” of health (1995, p.77). Frank explains: “the plot of the restitution story has the basic storyline: “Yesterday I was healthy, today I am sick, but tomorrow I’ll be healthy again” ” (p.77). These stories can be told prospectively or retrospectively and they are the type of stories I invited from the women who talked to me. They are stories of recovery. Frank notes that they are the “culturally preferred narrative” and that within these illness stories “Medicine’s hope of restitution crowds out any other stories” (p.83). Whilst I have sought restitution stories I have invited some of the stories that have been crowded out by Medicine.

The second type of stories described by Frank (1995) are chaos stories. He describes these stories as “chaotic in their absence of narrative order”, they defy the expectation of a ‘proper’ life, in which “one event is expected to lead to another” (p.97). They are not easy to listen to because they reveal “vulnerability, futility and

impotence” (p.97) and in many ways they are “anti-narrative” – stories without a beginning, middle or end. Frank suggests that these stories can only be told in retrospect (p.98) since at the time of their living the person is unable to achieve any “distance from her life and no reflective grasp on it” (p.98). This description assisted some of my listening to the stories of the women participants in my project.

The third type of story proposed by Frank (1995) is the quest narrative. Frank understands such stories as “defined by the ill person’s belief that something is to be gained through the experience” (p.115). He suggests that such stories “afford ... the ill their most distinctive voice” (p.115). These stories convey illness as a journey which starts with a *departure* which often comes in response to a call, such as a symptom which cannot be ignored. The journey can be a “road of trials” and involves a transformation of the story teller for which they are to a significant degree responsible. The quest story implies that the teller “has been given something by the experience, usually some insight that must be passed on to others” (p.118). The final stage is the *return* where the teller “is no longer ill but remains marked by the illness”. Again this ‘type’ was a guide to my listening.

The transcription of sections of narrative as poetry is the approach I will discuss next, and like Frank’s typology, it draws on approaches to literature, and is a valuable guide to deep listening.

### **Use of poetic form in transcription**

A dilemma for qualitative researchers, and certainly for those using narrative approaches, concerns the wish to honour the story-teller, and their unique way of languaging whilst also analysing and interpreting. Kendall and Murray (2004) found one way of respecting the stories of people “living with and dying from, severe heart failure or lung cancer” (p.52). After their research team carefully listened to and studied the manuscripts of the participants, they experimented with the realisation that “not everyone speaks in prose” and that “at difficult times, people may launch into narrative poems” (p.66). Reading this chapter quite late in my analytic process I returned to my transcripts and became more aware of the poetic form of parts of the narratives. When I transcribed text into poetic rather than prose form, I too was able, as researcher and analyst, to approach the text “more slowly”, to pay attention to “patterns of sound, image, and ideas,” and to experience “more emotional engagement” (Kendall & Murray, 2004, p.68). The process of accessing poetry within the data is “time-

consuming” and cannot be used across the complete data set. Kendall and Murray found, however, that it was valuable to use alongside other analytic approaches, and I have followed this pattern. They found that poetry helped them to “find a voice of feeling, a voice to explore not only what happened but how and why, and what it meant to us as emotional beings” (p.69).

This approach is to some extent intuitive, and I was able to draw on the experiences I had many decades ago of studying English literature. This experience has also informed my search for sub-texts and for stories within stories, and considering influences such as readily available cultural stories and myths. In the next section I will describe another approach to narrative which has informed a significant part of the analysis.

### **Strategies in storytelling**

Stories of women surviving the violence of rape are necessarily set against a societal landscape which includes well known myths associated with rape. Draucker and Hessmiller (2002) have studied the narrative of one college student who had experienced four date-acquaintance rapes. The authors were particularly interested in the structure of her stories of each rape, rather than the content.

The shape and content of a narrative reflect not only the lived experience of the teller, but also the shared stories which are available in each woman’s community to use as a framework for telling, languaging and shaping their own life story. The teller has an audience for their story and Draucker and Hessmiller note that the telling also serves a function. In the narrative they discerned four stages in the telling of each rape: “the initial condition, events leading up to the rape, the rape, and events following the rape” (p.208). The authors comment how ready the woman, for whom they use the name Sarah, was to tell her story in detail and at length. Significantly, her story reflects the “discourses of society” (p.227), including myths about rape and intimate partner violence. These myths “locate the violence within individual and relationship pathology” (p.229). Sarah’s story served the function, in part of “counteracting the cultural myth that women do something, or fail to do something, that provokes the violent acts of men” (p.231). She had “the burden of disputing the myth that women deserve to get raped if they are alone with a man in his home or in his car” (p.231). She disputed the myth by explaining how she happened to be in the situation where she was raped and that it was not a choice.

I have reviewed in the previous chapter some of the assumptions, myths and stigmas that exist in our culture and society around women and depression, and I have been encouraged by Draucker and Hessmiller to look for aspects of the telling of their stories which challenge these taken-for-granted assumptions.

### **Characters, themes and plots**

All the approaches to narrative analysis just outlined have underpinned the work of this thesis. However, before deciding the usefulness of a particular approach I needed to follow the basic analytic process outlined by Riessman (1993). She reminds narrative researchers that we need to pay attention to “the setting, characters and unfolding plot” (p.10). Michelle Crossley (2000) suggests that the process of analysis follow a number of steps. The first is “reading and familiarising” and this is followed by “getting a grasp of the principle elements” (p.89). She uses the elements suggested by McAdams (1993), narrative tone, imagery, and themes, but adds a stronger focus on “dominant themes” (Crossley, 2000. p.90) and suggests a final stage of “weaving all this together into a coherent story” (p.93). Some researchers include this step in research reports, using the stories they produce as one of the sets of data for carrying out their analysis. Marshall (2005) used this approach in her study of the stories of children living with learning disabilities. One advantage in her work was that she was able to check back with the children that they were happy with their story the way she had told it, and she read some of them their own story out loud. This was particularly appropriate for the age group she was working with. I have adapted this approach in my thesis to the introduction of the participants. These introductory stories are included as Appendix F.

### **Conclusion**

In this chapter I have introduced some of the specific ideas which underpin narrative research and then discussed a variety of approaches to narrative analysis. This chapter serves as a link between the theoretical ideas discussed in Chapter One, the existing body of published theory and research on depression and recovery discussed in Chapters Two and Three and the practical information about the way I carried out my research which will be presented in Chapter Five. Narrative research does not propose any one particular method of data collection or analysis, and there is no single theorist associated with the approach. This openness is one aspect of the approach which ‘called out to me’ and I have used Chapter Four to explain in more detail the particular aspects of narrative research which I have selected to inform my work.

## Chapter Five: A Fascinating Process

*This is always a fascinating, sometimes aggravating, process of weighing pros and cons, reaching and revising feasible, optimal rules, and often making compromises for the sake of practical limitations. Yet... this process need not curb the academic excellence of the final, chosen procedure and its application. The shared reflexivity and open disclosure of the researcher's dilemmas guarantee a fair, mature, and critical dialogue between scholars and their readers, a dialogue that gives the field of narrative research its energy and drives us all forward.* (Lieblich, Tuval-Mashiach, & Zilber, 1998, p.171)

Having already discussed the choice of a narrative inquiry methodology, and the evolution of my research question, in this chapter I will explain and reflect on how I carried out this research project. I will begin with selection and description of the participants, followed by descriptions of the data collection and data analysis processes. The final section of the chapter concerns rigour and ethical considerations. The discussion of ethical issues is positioned at the end of the chapter because it has most meaning when the reader already knows how the participants were selected and how the data was analysed. The entire research process involves ethical thinking, reflection and decision-making.

Throughout the chapter I will weave in the story of how I have attempted to carry out this project in a way that acknowledges the authority that I assume, but also enables the reader to hear the voices of the women who told their stories.

### ***Participants***

#### **Recruitment**

The participants in this study were a purposeful sample of 18 women obtained through advertisements and networking. Recruitment took place across a wide area of the North Island of New Zealand in 2000.

Advertisements displayed in public places were the major method of recruitment. Two styles of publicity were used, a poster displayed in public places (Appendix A i & ii) and an advertisement (Appendix B) to appear in regional newsletters of the New Zealand Association of Counsellors.

The 'poster' was displayed during March and April, 2000 in the following places:

- Community Centres

- Libraries
- Women's Centres
- A community based gym
- A women's bookshop

When there had been little response to version (i) after two weeks, a second version was designed to appeal to women who wanted to help others through sharing their experience. The notices in the gym were accompanied by a leaflet (Appendix C) acknowledging my membership of the gym and targeting women who may have used physical exercise as a way of coping with depression.

The advertisement for counsellors was placed in monthly newsletters of the New Zealand Association of Counsellors (NZAC). I wished to interview counsellors individually, but also to invite them to meet as a group. I expected that they had reflected on issues related to treatment and depression and could discuss my preliminary findings.

The third approach to obtaining participants was through personal networking. In 1998 I had carried out research which asked "What do General Practitioners offer women who present to them with symptoms of depression?" A number of women asked: "When are you going to talk to the women?" Many wanted to share their own stories and make their experience available to other women. A month after I started recruiting I contacted each of these women by e-mail or letter explaining the research selection criteria in the same words used in the public advertisements. I included a statement such as "I have no worries about getting sufficient participants, so there is no pressure on you to take part. I know that you have expressed interest, but also that you have a busy life, so will be happy which ever way you decide." In this way I reduced any possible element of coercion.

As a result of these recruiting procedures I had inquiries from 36 women. After they made contact I carried out a preliminary interview, usually by telephone, sometimes in person, and in one case in a series of e-mails. The outline for this preliminary discussion is attached as Appendix D.

## **Participant Selection**

Through the procedures described above eighteen women became participants. Coyne (1996, p.623) emphasised "appropriateness" in the choice of "informants" for high quality research and Morse (1994, p.228) suggested that a "good" informant is one who is "articulate, reflective, and willing to share with the interviewer". The women in this

study needed to be willing and able to tell a personal, and at times painful, story. They needed the qualities that Morse mentioned, but I also hoped that their stories could be complex, self-reflective and contextualised. They were what Wengraf (2001, p.102) described as an “intensity” sample: one which consisted of “information-rich cases that manifest a phenomenon intensely, but not extremely”. I have also employed “homogeneous sampling” by recruiting the sub-group of counsellors who had experienced depression, five of whom participated in the group discussions. Homogenous sampling “focuses and reduces variation” and “facilitates group interviewing” (Wengraf, 2001, p.102).

I employed a small number of specific exclusion and inclusion criteria. I have already discussed the reasons for studying women. I restricted age to over 18 years assuming that women would need to be in young adulthood to have had the experiences I wanted to explore. I also required fluency in English, since I would be conducting all interviews myself.

Decisions about the wording of the criteria were more complex. I did not want to use diagnostic language such as ‘clinical depression’. So, in spite of the “almost hegemonic status” of the DSM with its “biomedical conceptions” of depression and other mental ‘disorders’ (Stoppard, 1999, p.81) I did not require a formal diagnosis of depression. Many of the women I was seeking would never have sought a professional opinion, and it was important that they decided themselves whether their story might be relevant.

The first criterion for inclusion, as advertised, was that women “In the past, have had their life seriously disrupted by the experience of depression”. Women who had experienced temporary sadness, ‘uncomplicated’ grief or relatively low level ongoing depression would not have told stories relevant to the research question. I decided that having their lives “seriously disrupted” best described the experience I wanted to be central to the narratives. It will be apparent in the findings about the worst times, that this criterion worked well. The participants all experienced distress which would have met the DSM-IV-RV criteria for a diagnosis of “major depressive disorder” (American Psychiatric Association, 2000).

The second criterion was that the women “now have a life that is not seriously disrupted by depression”. These words, rather than ‘recovery’, were chosen thoughtfully. When I was planning the research, in late 1999, I talked with a number of women who had experienced depression and the majority of them understood recovery



to imply that depression was no longer part of their life. This was in contrast with the definition being used at that time by the New Zealand Mental Health Commission, which defined 'recovery' as "living well in the presence or absence of illness" (Lapsley, Nikora, & Black, 2002, p.9). At the time that I was planning my research I was aware of participant selection issues which had arisen in the Mental Health Narratives Project, later reported in *Kia Mauri Tau!* (Lapsley, Nikora, & Black, 2002). Some members of "the local mental health community" wanted to take part in that project by telling their "success stories" but did not meet the criteria if they were still on medication or had "made use of mental health services during the last two years" (Lapsley, Nikora, & Black, 2002, p.9). Lapsley and her colleagues became aware of:

.... just how highly charged the term "recovery" is in mental health circles. .... it became clear that there is a strong need for our community to hear the "success stories" of those who live rich and satisfying lives, despite an ongoing mental health problem (p.9).

In my research I wanted to hear such stories. I did not mind if in their less disrupted lives they were continuing with medication, therapy, massage, physical activity, homeopathic cures, or any other professional or non-professional form of 'support'. It seemed likely that using the term 'recovery' in advertisements would exclude some women whom I wanted to include. In *'Kia Mauri Tau!'* the expression "overcome the disruption that mental health had made in their lives" is used (p.8), and I chose to use this clumsy, but more inclusive language in my criteria. I believe this ensured that I had some participants who had learned to live well in spite of depressive symptoms still being a part of their lives.

The third criterion, concerning 'non-professional' responses, was the most difficult to put into language that would meet the aims of the research, and be intelligible to potential participants. My intention will be clear, from the previous chapters, but it was not easy to find a succinct way of wording this. I decided that by mentioning some of the 'professional' solutions, such as "counselling, therapy or medication" and then stating my interest in 'other' responses I would give women sufficient information to decide whether to contact me. This was a successful strategy, and women who were uncertain talked with me in the preliminary interview and decided then whether they met the criteria.

I decided to make no further limits on who would take part, and was willing to accept women of any ethnicity, sexual orientation and country of origin. After

discussions with experienced narrative researchers I decided that I would limit the number of women I interviewed to somewhere between 12 and 18. This was recommended as a number which would give sufficient information, but not provide so much data as to make analysis too time-consuming given that I was a sole researcher working within a limited time frame. Jones (2002, p.465) commented that sample size is always an issue for discussion in qualitative research, and noted that this is because “the emphasis is rarely on sheer numbers of participants”. The important questions are more to do with “the quality and depth of information elicited”. Patton (1990) had earlier reached a similar conclusion, suggesting that whilst the “sample size” related to the purpose of the study, it was also dependent upon “available time and resources” (p.184).

Of the thirty-four women who expressed an initial interest eight became interested through the networking process, nine through advertisements in libraries, two through the bookshop, three through the gym and twelve through NZAC newsletters. Five women contacted me and discussed the project before they were sent a Participant Information Sheet (Appendix E), the remainder contacted me by telephone, e-mail, or post and were sent the Information Sheet so they could decide whether to have a preliminary interview. Some of the women who had come through personal networking had already decided they wanted to take part, and I knew they were suitable participants so interviews were arranged without a formal preliminary discussion.

Nobody was turned down after their preliminary interview, but six women did not get back to me after receiving project information. A further ten decided they were not appropriate after the interview. Of the ten, seven realised they did not fit the criteria either because they had relied too much on professional interventions, or because their lives were still too disrupted. One reluctantly withdrew because she moved to a distant part of New Zealand. Another woman decided she was not appropriate because of her connections with me, and one woman withdrew after her interview.

The final group of eighteen women came from a variety of contact points:

- five from networking,
- five from NZAC newsletter publicity,
- four from library advertisements,
- three from the gym
- one from the Women’s Bookshop.

## **Participant Characteristics**

I did not ask for any specific demographic information, and the following descriptions have been gleaned from the women's narratives. I saw no reason to pre-judge which of each women's qualities was important enough to include. I have summarised information that the women chose to include in their stories.

The participants ranged in age from 32 to 70 at the time of the interview, and their lives had been most seriously disrupted by depression between the 1950s and the 1990s with the majority of the worst periods clustering in the 1980s, and then in the 1970s. At the time of the interviews twelve of the women were in committed, stable, long-term relationships, two of which were with same-sex partners. All but five of the women were in paid work, mostly of a professional nature. Two were retired, and one was on maternity leave. By the time they were interviewed all but three of the women had a tertiary education qualification. Six of the women had been born outside New Zealand, and had come here as adults. Two of the women talked of their ethnic origins, one of whom was Jewish, and the other who identified as having Māori ancestry. More detailed introductions to each woman are attached as Appendix F.

## **Data Collection**

The major form of data collection was through individual interviews. The women were given a choice of where the interviews would take place; seven were interviewed in their own homes, six in my home, four at the university where I was studying and one in her own work place. In this section I will first discuss the way that the interviews were conducted. I will then discuss the focus groups, which provided a contribution to the early stages of the data analysis.

## **Individual Interviews**

The interviews were designed to elicit narratives from each woman about how depression had disrupted her life and about her journey toward recovery. The women knew the kind of stories I was interested in, both from the Participant Information Sheet (Appendix E) and from the preliminary interview. The interviews were carried out with an understanding that an interview "is a social accomplishment" (Elliott, 2005, p.19). I expected to obtain data that could be analysed in terms both of *what* was said and *how* it was said. I allowed the women to guide their own narrative as much as possible, with only minimum prompts and encouragers. I was guided by a pre-prepared interview outline (Appendix G) which I was aware of, but did not refer to until the end when I

read it through with the woman to check whether there were issues that she had not talked about, but which she wished to comment on. Mostly the topics had already been covered. Elliott (2005) points out the risks of interrupting interviewee's stories when the researcher is wanting "narrative responses" (p.31). She argues that one of the most important qualities of an interviewer in narrative research is that they be a "good listener" (p.31) and make sure that they do not stop a story because they think it is irrelevant, thus blocking of information that follows on and may be relevant.

Hollway and Jefferson have discussed interviewing in qualitative research (Hollway & Jefferson, 2000). They researched fear of crime and were interested primarily in the content of the interviews, but were also sensitive to the way that meaning was constructed in the interviews. I wanted to ensure that my method of interviewing resulted in data which could legitimately be analysed in both these ways. I also needed to be aware of the influence I would have on content and structure of the narratives.

It is not possible to be a neutral interviewer. It is important, however, to maintain awareness of what one's influence might be and to decide whether to attempt to reduce this impact. Elliott (2005) commended Mishler (1986) for taking seriously the role of the interviewer in producing data for qualitative research. His initiative in the nineteen eighties was not followed up in any widespread way. Fifteen years later Hollway and Jefferson (2000) lamented the common practice of researchers reporting on their interview based research without ever presenting detail about the "interviewer's questions" (p.10). If the data in an interview is co-produced, and the interviewer is both the instigator of the narrative and the audience for its production, then it is important to know what the interviewer has said. In my study the Participant Information Sheet explains my intention. However, when the interviews were transcribed, they confirmed that I had created eighteen different versions of my verbal invitation. I choose to disclose some of this variety, and recognise it not as a weakness, but rather an indication of the interactive nature of the interview.

When I was interviewing Anne, a participant who had become involved through my personal networking and who had already discussed the project with me on a number of occasions we began with a brief focusing conversation:

*Jan: So if you- just when you feel comfortable - you just tell me...  
What I really want is your story of your life with depression. Like  
how depression came into your life and when, and what it was like  
when it was in it's....*

*Anne: In its peak form?*

*Jan: ... mm .... most overtook you and then how it's ....how your life and depression have intertwined and linked and connected.*

*Anne: Okay. Yeah, cause that's really important that it's not just the major episodes is it?*

*Jan: No.*

*Anne: It's a life phenomenon.*

*Jan: I think so.*

*Anne: And certainly for me. So yeah okay. Um... I was born into a family of ....*

Anne then proceeded to tell her story, with very little interruption from me.

Other women asked for reassurance about the story that I might want to hear. This was especially so if they did not know me, and were not familiar with research, or with the interview process. This uncertainty has been acknowledged as common in interviews, especially when they are "open and fluid" (Edwards, 1993, p.191). Christine, was unsure, and asked me to explain what I wanted to hear. My field note at the time said: "*Christine had asked for some guidance about what aspects of the story I was especially interested in, she did not want to just "start in cold" to telling her story*". My opening was thus much more elaborate and detailed than the conversation with Anne:

*Jan: Right, I've got a list of the things that I want to have covered. But what seems to have happened is that people cover those anyway, in telling their story. But what I'll do is just quickly run through them, to put your mind on them. What I want you to do, is just to tell me how depression came into your life, how it was when it was at its worst, and how come you think you've got past that worst stage. You've got to where you are now, where it doesn't disrupt your life as much. What it's like now. Now, in the telling of that, or, whichever way, I'm hoping that we can cover, and I'll read them out, and if at the end there's things that don't seem to be covered, I'll ask you, but you'll probably fit them in any way. Umm, things like: how did you come to use the term depression? How did you use that for what was happening? Do you have any ideas about how or why it came into your life? How was your life at the worst times? What sort of things could you do? How did others treat you? What did you think was happening? If you can remember. Was there a particular time after that when you noticed that it was less disruptive? Like was there a sudden turning point, or did it just suddenly kind of disappear? Ummm, and how it feels now. Is depression still a part of your life from time to time? Or is it kind of a working around in case it might be, or do you not think about it much? Have you found different ways of living that make your life less disrupted? Like are you doing things, thinking things, differently, being different now? From how you were at the worst times. That's a kind of personal thing, but I, are there other things, or people or actions or thoughts that have helped you to change? For the better. So what other*

*influences, maybe books you've read, or activities ----? Did anything, or anyone make the change and progress more difficult? So, it's what things helped, and what were other things that made it more difficult. And, do you feel there are any things about you which made it possible for depression to come into your life? Now you don't have to answer any of these, some of them you may choose not to talk about, and that's fine. But those are the kind of things -*

**Christine:** *I'll probably need a bit of scaffolding with these. Because, I mean, the episodes go a long way back, well I think they go a long way back. Ummm. And so I'll, and, and they are at the back of my mind at the moment. Cause I'm good at the moment.*

**Jan:** *Great.*

**Christine:** *So, I'll reprise.*

**Jan:** *Is it OK? Do you think you should be digging them up? Then?*

**Christine:** *Not a problem.*

**Jan:** *Right.*

**Christine:** *Not a problem. No. So what do you want me to start with?*

**Jan:** *Whatever you feel like starting with, actually. Because it might be you want to start in the middle, at the worst time, so then you can reflect back, or it might be you want to start when you first...*

**Christine:** *Right. OK. Well I had what ummm, possibly, could be a different form of depression ....*

Christine then went on to tell her story with little need for any further reassurance that she was 'doing it right'. I kept on talking for so long, because, as I commented in my field notes, I was watching Christine's response. I was continuing to 'hold the floor' until I felt she looked ready to begin talking; until she had relaxed a little, settled back in her chair, and seemed more at ease.

Each interview was different. Atkinson (2002) asserted that life story interviewing "can be approached scientifically, but it is best carried out as an art". He also suggested that the interviewer needs to be "flexible" and able to "adapt" to different circumstances and different interviewees. This was the approach I used.

I have cited my introduction to Christine's interview in its entirety because it illustrates not only the flexibility, responsiveness and individuality of my approach, but also because it illustrates other features of the interviewing process. The interview provides information to an audience, and in this case the most immediate audience is myself, the interviewer and researcher. At another step removed is the potential audience of readers of the thesis, and groups whom I may talk to about the research. All the women said specifically that they were taking part because they wanted to help other women whose lives were disrupted by depression. Many of them, like Christine, turned to me for guidance about the kinds of issues that might be helpful to other

women. I tried to avoid influencing the stories as far as their content was concerned, except for the criteria used to select the participants. I believe that this transcription of my introduction represents well how I tried to open up possibilities, without determining the plot, characters, themes or sequence of the story.

It has been suggested (Burman, 1994) that it is both important and ethical to carefully plan the kind of questions to include in an interview, and to share this knowledge with the participant. I did this through the information sheet, and also by referring to the interview guide when each woman seemed to have reached the end of her narrative. Nevertheless, in spite of detailed planning, the interviewer still needs to do a lot of “thinking on your feet”, and at times may be “lost for words” (Burman, 1994, p.54). The section of an interview reproduced above illustrates the informal but intentional nature of the interviews.

Each woman discussed and signed a Consent Form (Appendix H) at the start of the interview. This ensured that they knew the interview was being audio-taped and that they were able to withdraw from the project or raise any concerns.

The final issue in this section concerns the length of the interview. This is another area in which I determined the boundaries. I suggested that the interview would last between 60 and 90 minutes, and this happened, with one exception (Fiona, whose narrative lasted 2 hours). Elliott (2005) reviewed literature on the appropriate length of interviews for narrative research. She considered practicality, the amount of data that can reasonably be analysed, and the need to allow participants to complete the telling of their stories. I considered all these matters and gave each woman the opportunity to have a second interview if they wished. However, as Elliott suggests, once the women had been given a suggested interview length they seemed to sense “how much detail to provide” (p. 32).

The individual interviews provided me with 18 audio-taped interviews, each lasting between 80 and 120 minutes which was the major data for the project. The supplementary source of data was a series of three group meetings with five of the participants.

## **Focus Groups**

I sought early feedback from a focus group, made up of women participants who had experienced depression, and had also practised as ‘professionals’ with other women whose lives had been disrupted by depression. Focus groups have been defined as “a

research technique that collects data through group interaction on a topic determined by the researcher” (Morgan, 1996, p.130). Historically, it was only during the last decade of the twentieth century that the focus group became a significant method of data collection for social, as opposed to market, research (Madriz, 2003). Morgan has described focus groups as a “flexible data gathering technique” (2002, p.141) and other authors have recognised the variety of processes that are possible within this approach. Fontana and Frey (1994) acknowledged that focus groups can cover the whole range from structured and tightly directed to informal and spontaneous. The groups that I ran were informal. I used them as an opportunity to consult with women who were ‘experts’ on living with depression, and on their own recovery.

### ***Recruiting group members***

The last of the individual interviews took place in August, 2000. I spent the following three months transcribing and gaining a preliminary understanding of these interviews. At the same time I was talking with some of the women about the possibility of their being part of a series of group discussions. I had already included the following statement in the advertisement in the NZAC newsletter (Appendix B):

I am also wanting to work collaboratively with counsellors who have themselves experienced depression, and found a way to re-build their lives. As well as interviewing them I plan to bring these counselling women together in a group. I hope we can explore some of these experiences, and the ways that living with depression and then reducing its effects, has impacted on their professional work as well as their personal life.

This invitation was extended to nine appropriate women after their individual interviews. Five were both interested, and able to attend. We had three two hour meetings at which I provided food. We met in a comfortable place at the university. I facilitated the groups. The women agreed to Hilary Lapsley, who was at that time my principal supervisor, and an experienced narrative researcher, attending and co-facilitating. The discussions were audio-taped, and all the women gave written consent for this process (Appendix I).

### ***Why groups as well as individual interviews?***

The intention for holding the groups was stated in my application for ethical approval. I hoped:

..... that these women would share with me in beginning to formulate theory concerning the social construction of depression, and the



dominant discourses relating to depression and its treatment in recent times in the history of New Zealand. I hope that together we can formulate some suggestions of strategies for coping with and/or overcoming the experience of depression.

The questions that interested me concerned the significance in the recovery process of the transpersonal, or spiritual and also the role of friendship. These wonderings had emerged from my early analysis of the individual interviews.

The decision to involve some participants in these discussions was made for a number of often interconnected reasons. Firstly, it was a recognition of the ‘expert’ and complex nature of these women’s knowing. Secondly it was a forum in which the balance of power would be different from an individual interview, because of the involvement of five women. Thirdly it would allow the women to develop ideas collaboratively, and to support one another in this process.

### **Participants as ‘experts’**

In keeping with the purpose and design of this research project, I approached the women in both the individual interviews and the group as experts. I spoke with the women who wished to participate in the groups by telephone or connected by e-mail and then sent them a discussion document (Appendix J). This document stressed the value of their experience and my hope that they could explore together some of the wonderings that were emerging from my analyses. The questions I listed were:

- Are there connections between the story of how depression came into each woman’s life and the story of how they moved beyond the major disruption of depression?
- How does gender (being a woman) relate to the experience of depression?
- What are the interactions, if any, between professional and lay wisdom about the development, maintenance and recovery from the experience of depression?
- What words do you choose to use about your experience of depression? Do you understand depression as a ‘mental disorder’, a ‘disabling mental health problem’ or a time of ‘mental ill health’ or would you use some other language?
- How has the experience of ‘being depressed’ informed your work as a counsellor?
- How has being a counsellor influenced the way you have ‘handled’ your experience of depression?

My questions clearly set parameters for the group meetings. I also invited the women to suggest discussion topics. I summarised their feedback in written form (Appendix K). All the women agreed with my ideas but also expressed interest in “different therapeutic modalities that have been helpful in treating depression”, the

“connection between depression and cultural issues”, “spiritual” language as well as “medical/health” language, and ideas about “depression as a state of being”. By inviting this input, I was recognising the ‘expert’ value of the women’s experience and ideas, and setting the scene for group discussions where they could take the lead. I made it clear that I was not a participant, but a facilitator and curious listener. They knew that I was a counsellor whose life had not been seriously disrupted by depression. I had made this personal disclosure at the time of each individual interview, but decided that it was important to reinforce this at the beginning of the group meetings.

### **Redressing power imbalance**

Michelle Fine (1994) has written about social science as a “tool of domination” (p.70) and she invites researchers to “expand our minds and constrict our mouths” (p.72). As discussed earlier, I had tried to do this in the individual interviews. The group meetings were another site where I was somewhat able to achieve this silencing of myself, and thus to listen more to my “informants”. The evidence for this lay in part in the decisions that the group made which were at times contrary to my expressed interests.

One example concerns the ‘memory-work’ exercise I had planned. I distributed an outline of this process at the first group (Appendix L and M), and let the women know how enthusiastic I was about it as an activity. At the second group they quickly came to a unanimous agreement that they were not at all interested in using this structured process. They were apologetic, and said they would take part if I was really committed to it, but that they would much prefer to have me ask them directly about issues of interest. They were asking my permission to follow a different format, making it clear that I still held the ultimate position of power, but also indicating that they felt able to debate the process. I decided immediately to abandon this process, and was pleased by this demonstration of group decision-making. Burman (1994) has pointed out the importance of this flexibility. She commented that “rigid adherence” to a schedule “can intimidate the participant or can fail to follow the participant’s train of associations and perspectives” (p.54). I felt able to trust the process I had set up, and considered this ‘rebellion’ an indication of the mutual respect between myself and the participants.

### **Developing ideas collaboratively and supporting one another**

Esther Madriz (2003, p.364) has written about the value of groups as “gratifying and stimulating” experiences which can enable marginalised voices to be heard. She has a

particular interest in feminist research facilitating women of colour in dealing with oppression. Women who have lived with mental health problems are often marginalised and oppressed, and not valued as experts, even on their own lives. I hoped that the group situation would enable the women to have more power over the process and the content than they had experienced in the individual interviews. At the end of the first two hour meeting the women reviewed its value for them. They also reflected back on the experience when we met for the second time. The feedback was that it had been an experience which many had found surprisingly moving. Two of them described how ‘shaky’ they had felt afterwards, but all were willing to return and to become once again, vulnerable.

My approach to the groups was to spend most of the time sitting back quietly, and listening in on the conversation acknowledging the women’s expert status. I sometimes let them know what I was wondering about, but mostly I was interested in the ways that they discovered, through conversation, more about their shared understandings of depression and recovery. The women were also each other’s audience. Gabriel (2004) discusses the voice of experience and the voice of the expert. He explores the importance of the narrative as a “sense making feat” and notes how “fragile” stories can be when the teller is confronted with two “deadly questions”.

The first one is the “So what?” question, the abyss that faces every story teller, when the story fails to carry meaning. A story can carry meaning, yet may fail the second test, the test of verisimilitude. In addition to the “So what?” question, which all narrators must face, storytellers must also face the “Did it really?” question, which questions whether the story accurately represents reality (pp.171-172).

The women were able to establish quickly that they would not question the meaning or accuracy of each others stories. The stories became more robust, and the women less fragile as story-tellers because of the presence of an audience in whose presence they were not ‘other’.

## **Recording and Organising of Data**

All individual interviews and group discussions were audio-taped. I transcribed all but two of the tapes myself, and in all commented where relevant on the emotion conveyed by the woman. For example, I would note if she was tearful, if she spoke very softly, or if there was a long pause. The transcribing was done within a week or two of the interview, whilst it was still vivid in my memory, and I also made notes after each

interview. Each woman had selected a name for herself and these ‘nom-de-plumes’ were used from the time of first transcription. The transcribed data was saved initially into the NUD\*IST data organising programme and a year later transferred to NVivo.

## ***Analysis***

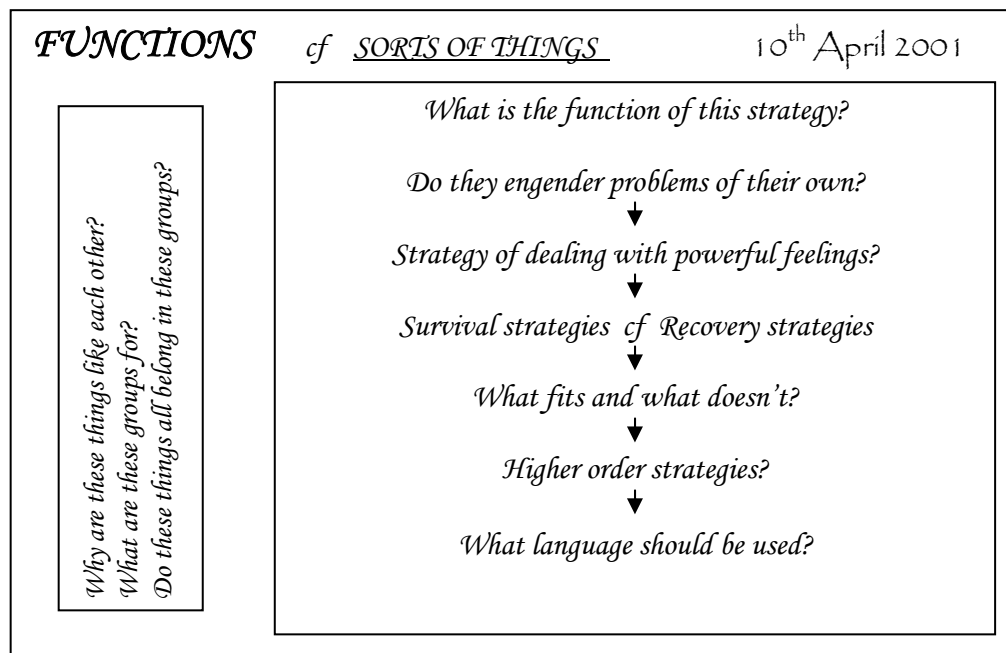
The process of analysis in narrative research is complex and “there is no set form of narrative analysis, rather the form depends on the researcher” (Yardley & Murray, 2004, p.92). The process used in this project evolved over many years, from before the first interview, until the writing of the thesis was complete. This section attempts to describe this process in an orderly manner, which cannot fully reflect the convoluted evolution of the five chapters of findings, and the final drawing together into a meaningful conclusion.

I began my analysis by listening over and over to the audio-tapes of the eighteen interviews. When I collected the data I was living in Auckland, and studying at Waikato University, a two hour drive south. As I travelled the road I played the interview tapes in my car. This became a very effective way to begin my analysis, since I had to listen without taking notes, and I had time to reflect on each woman’s narrative as a whole. I became very familiar with these narratives as spoken data at the same time as I was reading and re-reading them as written text.

I transcribed most of the interviews myself. This involved a different kind of listening. I needed to play and re-play some sections to be sure what word was being spoken. Often the hardest sections to hear were those spoken with the greatest emotion, so they were repeated over and over and became ever more familiar. As I transcribed I also began to take notes, to commit my wonderings to a journal. I was beginning the analytic process.

The first stage of the analysis of the narratives involved a search for structure in the stories. As I read and listened I began to discern some shapes to the stories. Initially I entered the data into the NUD\*IST software programme. I assumed a conventional story pattern and looked for five stages within each woman’s narrative; pre-onset, early onset, worst place, moving on and life now. More than a year into the analysis I acquired the NVivo computer programme and transferred the data to that because it was easier to work with. I had an increasing number of journal entries suggesting that the framework I had set up was not fitting with the data.

I had created over 300 codes and was not happy with the way I was fragmenting the data with a seemingly poor fit with the framework, and with codes not sufficiently grounded in the data. I made a decision to start again with NVivo, being informed by the work I had done, but starting without the assumptions represented in the NUD\*IST codes. Instead I started asking questions of parts of the narratives. In April 2001, for example, I was considering the recovery strategies women talked about. My journal notes are represented in Figure 2.



**Figure Two:** Representation of a page from researcher's journal, April 2001

At this point I had made a number of visual, graphic representations of the women's life stories, following the ideas of Tuval-Masiach (Lieblich, Tuval-Mashiach, & Zilber, 1998). Some of these are included as Appendix N. What arose from this new data processing was a different map of the journey. By 2003 I had developed a new set of journey stages which were better informed by the women's narratives, and which could hold all the data. These became the organising bases for the presentation of the findings into five chapters:

- Jolly Good Reasons (*the way the women talk about the reasons they might have become depressed*)
- The Seeds of Resilience (*the strengths women see that they had throughout the journey in and out of depression*)
- A Disrupted Life (*the worst times of depression*)

- Seeking Solutions (*when the women started trying things out to reduce the impact of depression*)
- A Life no Longer Disrupted (*how the women reached a life which was not seriously disrupted by depression*)

The naming and ordering of these chapters has changed as the analysis proceeded through the stage of being synthesised and written up. I gathered together all the sections of dialogue that fitted into each of these five stages of the journey, and then read and re-read the women's words. I developed sub-categories within each group, and also took notes about the overall impression of each part of the larger narrative. Some of this analysis was done using NVivo, but at times I felt drawn to work with a hard copy and cut and colour code sections of text, creating physical piles of data. I have included a copy of some of the NVivo codes that I had devised by the end of 2005 (Appendix O).

When I came to analyse the stages of the journey I found that each called for a different approach. I have introduced this idea in the previous chapter, and will now briefly explain the basis for the analysis of each stage. Further detail is included within each of the findings chapters.

### **Jolly Good Reasons**

When analysing the data from this part of the journey I first considered the proportion of their story that the women devoted to their understanding of how they came to be depressed. This was important because there was a marked variation in emphasis. I then considered how the women had drawn on readily available cultural stories to understand how depression had come into their lives. The analysis of this chapter reflects the contextual issues that have been associated with depression as discussed in Chapter Two. This in turn reflects the availability of such stories to myself as researcher as well as to the women.

### **A disrupted life**

The analysis of this stage draws on the work of Arthur Frank, and the stories of this time fit well with his description of "chaos stories" (Frank, 1995). In recognising this I have needed to explore patterns of speech, and do some micro analysis of the language and the tone used by each of the women. I also consider metaphors and the analogies that the women use in their stories. I listened more intently to the language because of

the work I had read about women's use of metaphor in therapy as a sign of recovery (McMullen, 2003).

An early stage of the analysis of each chapter involved my 'mind-mapping' the major ideas that I could discern in the text. I have included one of the diagrams related to this chapter as Appendix P.

### **Seeds of resilience**

This section of the narratives emerged very clearly from my reading and re-reading. I surprised myself by discovering chunks of data which did not fit into any of the categories I had expected. At the time that I was struggling to make sense of this I read the work of Draucker and Hessmiller (2002), which had not been published at the time I started my analysis. This work has been discussed in the previous chapter, and it formed the central core of the analysis of these parts of the stories. It seems that the women included comments on their strengths and positive habits to explain how they had a continuing alternative story of strength and resilience that existed alongside the chaos story of the worst times. Whilst this story had become muted it was ready to be picked up again and strengthened as they found ways to overcome the worst times.

### **Crawling out is so hard**

The two chapters on recovery offer the most significant data in relation to my research question. There was a large amount of text to consider, and again I needed to read, and re-read over many months before a structure emerged that made sense of and honoured the narratives. The material was coded into a large number of branches of the tree using NVivo. Then I worked to discover some patterns, sometimes using mind maps. One of these is attached as Appendix Q. What I came to realise was that the solutions the women were offered, or discovered for themselves could be grouped into two major parts. One part was the symptom relief, which appears two thirds of the way down the mind-map. In order to reach this place the women make a number of false starts. They also found some things which helped in a temporary way, but did not amount to a sense of recovery. This chapter came to include all these attempts, whether they were successful or not.

I devised a three dimensional grid to assist my understanding of this material. One dimension involved whether the attempt proved to be a false start or whether it became the beginning of a journey beyond disruption. A second dimension involved the kind of solution the woman talked about having tried; medical, psychological,

interpersonal or ‘other’. The third dimension was concerned with the initiation of the attempt, and whether the woman talked of initiating it herself, of it being initiated by a family member or friend, or by a professional. Figure Three gives a representation of this grid.

	<b>FALSE STARTS</b>		<b>BEGINNING TO CRAWL OUT</b>	
	Initiated by		Initiated by	
	Self	Others	Self	Others
Medical				
Psychological				
Other				

**Figure Three:** Analytic grid for ‘Crawling out is so hard’

An example of how I used this grid would be that the cell marked with diagonal stripes would contain the possible solution of :

- having Cognitive Behavioural Therapy sessions with a psychologist (Psychological)
- at the suggestion of the woman’s partner (initiated by other),
- and this solution not having any success in relieving the impact of depression (false start).

These three dimensions were the most regularly spoken about across the range of attempts the women talked about concerning their search for relief from depression.

### **Getting the formula right**

Finally all the women found a combination of things which helped them move their lives away from depression and towards meaningfulness. In this final chapter I wanted to do some very simple qualitative analysis which would lead to a list of ideas about the kind of non-professional things that the women spoke of as being useful. I also wanted to look beyond a list of successful solutions to the ‘nature’ of the things that they talked of as having worked. This involved reading the texts at different levels, and then trying to synthesise and understand what some groups of things had in common. This process was initiated by the five women in the group sessions. Out of their discussions I was able to see some commonalities amongst the very different solutions. I devised my own diagrammatic system to present the sequence and length of different stages in each woman’s journey. It was clear that each woman had an account of a particular



combination of things that worked for her, and I wanted to maintain the embodied nature of this part of the journey, to present a catalogue of their stated solutions in an holistic and respectful way, and yet to look for meaning across all the stories. Finally the decision I made was to present each woman's stated solution separately. I chose to tell a condensed version of each woman's story of discovering her ways to overcome depression.

### **Poetic transcription**

Once I had written a coherent story about each stage of their journey I was aware once again how much the fragmentation of the data loses some of the impact of the stories. For this reason I decided to start each chapter with a longer section of one woman's narrative. The section was one I had recognised as a 'poem' in the way discussed in the previous chapter (Kendall & Murray, 2004). I chose poetic stories which reflected a significant issue for many women as they spoke of their experience of that particular stage of their journey to recovery.

### ***Ethical Issues***

It has been common to consider ethical issues in qualitative research under headings such as 'doing no harm' and 'ensuring confidentiality' but within feminist and critical research, and inquiries about sensitive matters such as mental health there is a need to acknowledge the complexity of ethical issues. Edwards and Mauthner (2002) stated that ethics, in relation to social research, refers to "the moral deliberation, choice and accountability on the part of researchers throughout the research process" (p.14). Frank (2002b) agreed, but went a step further, asserting that gathering personal narratives of "everyday practices"; "the local and contingent solutions that people have found to how they should live" was an "honourable vocation" (p.3). I have attempted to carry out my research in a way that is consistent with Frank's idea of ethical practice.

Formally I have obtained ethical approval through The University of Waikato, where I was initially enrolled (Appendix R), and also through the Auckland University of Technology where I completed the project (Appendix S). In practice I have had to make ethical decisions at every stage of this project. Grbich (1999, p.77) groups important aspects for postmodern and feminist ethics of research under the headings of "ongoing negotiation" and "reflective critique". This approach suits my project well, and I will use these headings and some of the sub-headings to present my ethical deliberations.

## Ongoing negotiation

### *What do we (researcher and researched) hope to achieve?*

Although I consulted with some women whose lives had been disrupted by depression before I commenced this research it was not a collaborative research project. It was my PhD research, and the achievement of that is an important personal goal. In acknowledging this I also have wider goals and I consulted when I could. For example, in discussing expectations with the five women in the group, it was apparent that we shared similar hopes that professionals would better understand and value women's experiences. Also we all hoped that the results would be accessible to women trying to recover from depression.

These hopes are idealistic, and, as one of the participants said; "I know about PhDs – hardly any one ever reads them anyway, so I don't need to worry about my story being recognised!" It is important that other outlets be explored. The women in the group discussed how their stories could be made available to women in similar circumstances. They hope that after the thesis is submitted I will join with them in writing up some of the findings in a book which will be more readily available to women living with depression. These women have stayed in touch with me since the interviews, and this intention persists.

I have already presented the findings at conferences and workshops in New Zealand, Australia and Finland. The audiences have included professional people involved with mental health, and also 'consumers' of mental health services. Often people who have lived with depression have come to me after the presentation, moved that stories so much like theirs are being told to an audience of professionals. Talking at gatherings of women many have commented that they recognised parts of their own lives in the stories. Seven of the women who participated in my project have heard me present some part of the findings, and have reported that it has been a valuable experience. Some have publicly identified themselves as being part of the project; others have remained an anonymous part of the audience.

It is my belief that this project will fulfil, in a relatively small way, its goal of increasing the chances of professionals understanding the journeys of women whose lives have been seriously disrupted by depression. Also, that it will encourage professionals and lay people to consider seriously the value of 'cures' other than those from the professional mainstream.

### ***How will confidentiality and anonymity be maintained?***

Christians (2003) explains that the major reason for confidentiality is to “safeguard against unwanted exposure” (p.218). I have attempted to provide such safeguards. Each woman chose a pseudonym to be used in all aspects of the project. Original names are on the Consent Forms and on the audio-tapes which are in locked storage separate from the project. The transcripts had identifying details removed or altered, and they were stored on my computer, which is safe-guarded with a password. Hard copies were stored in a locked filing cabinet.

The nature of narrative research, is that it may “provide a feel for the person, conveying the experience of having known or met him or her” (Lieblich, Tuval-Mashiach, & Zilber, 1998). I have chosen to use this approach so that this awareness of each participant as an individual with a unique story and particular strengths and needs is conveyed. Anonymity can not be guaranteed in the way that research which synthesises stories can (Mishler, 1986). The result is that anyone who knew a participant well and read this thesis would probably recognise the person. I made this clear to the women. One woman realised a few months after the interviews that her chosen name might be recognisable and contacted me with a replacement pseudonym that was more common. Others chose their pet name or one of their own given names, stating that they would be happy if they were recognised in the project, they were very willing to own their story. Some wanted me to use their own name but this choice would have been unlikely to have been acceptable to the ethics committees.

The part of this thesis that makes the women most recognisable is their introductions in Appendix F. I have sent this section to each of the fourteen women whom I was able to contact and they all appreciated the way they had been introduced and were willing to have their story included.

### ***How will accountability be addressed – particularly when suffering and injustice are evident?***

I am aware that the injustices faced by many women, through family violence, cultural violence and gender inequities as well as the stigma attached to mental health problems are not easily addressed. I feel accountable to the women, and this project has been motivated because of the awareness of injustice and misunderstanding that I have developed in my years as a clinical practitioner. It cannot be expected that one research project in New Zealand will make any significant difference to these issues but it is being carried out with a strong sense of accountability and commitment to change.

### ***How will the needs and concerns of the participants be addressed?***

At the beginning and end of each interview I checked out the well-being of the woman, and that they had the support they wanted. It was easier to address needs in the group where the balance of power was more equal. However, when I talked with participants the feedback I received about the process was very positive. One woman withdrew from the project the day after I had interviewed her, and said she had not been happy with the process. She was not specific about her concerns and was not willing to discuss them at the time.

The women did not expect to have any direct gain themselves, but wanted their stories to be available to help other women in the future. However, some were surprised at how much they had valued the chance to tell their story. When I rang a few days after each interview some acknowledged that they had been quite ‘shaken’ by the interview, but were still glad they had taken part. They had been surprised at how much emotion was still attached to things that had happened many years earlier. Recently I re-contacted fourteen of the women and they all remembered their interviews vividly, and wanted to update their stories. Many said how helpful it had been to tell their story; the telling reminded them how far they had journeyed.

### **Reflective Critique**

#### ***Were relationships non-hierarchical, respectful, caring and growth oriented?***

There is a power relationship between interviewer and interviewee. Gubrium and Holstein (2002) discussed this relationship from a post-modern standpoint, referring to Foucault’s arguments about power, agency and subjectivity. Within this context interviews can be understood as a form of “scientific surveillance” (p.8), and the individuals who are interviewed and who share their experiences and perceptions help to constitute themselves and the society through the process of telling their story. This understanding is consistent with my views of the self. Each woman is not a simple “vessel of answers” (Gubrium & Holstein, 2002), she is “an agent engaged in the production of knowledge”. However, the knowledge which she is engaged in producing is that which I, the researcher, have decided is of interest.

Erica Burman (1994, p.51) reminded her readers of a 1959 description of an interview as a “conversation with a purpose”, but invited us to consider thirty-five years later “*whose purposes* the conversation is pursuing”. Transparency about my purposes was one way of recognising and addressing this power relationship. Some of

my purposes coincided with those of the participants, nevertheless, it is I who seek to achieve a university qualification as a result of this project, not my participants.

The narrative approach can also be seen as a way of reducing the power of the researcher. Inviting narratives, rather than asking a series of questions has often been seen as a facilitative rather than a directive form of interviewing (Mason, 2002). Jennifer Mason notes that this is a relatively ‘hands off’ way to acquire data, even though the silent interviewer is not devoid of power.

This project concerns a ‘sensitive’ topic, and the participants are potentially vulnerable. Interviewing in these circumstances is much discussed in health research. Janice Morse (2002) has carried out research involving people who are “acutely ill” and “silenced” or “muted” by disease or injury (p.318). She questioned when it might be appropriate to interview such people. For my project it would not have been useful to interview women at the time their lives were most seriously disrupted. These worst times are only able to be reflected on and talked about coherently after they have passed. I wanted this reflective story. I wanted to know how the women made sense at a later time of their past experience with depression, and this was a condition of the narrative production. I called on the women to tell their stories at a time when their “biographical competence”, as Morse referred to it (2002, p.320) was at a high level. She suggested that many people value the opportunity to tell their story of “rehabilitation” and that for some “being interviewed enabled them to make sense of the overall illness experience” (p.321). Morse considered that interviews gathered at such times for the purpose of research provide “accounts” which have “had a chance to mature, to become fleshed with detail, and to deepen in perspective” (p.321). I believe that this has happened for the participants in this study. The phrase, “now that I look back” recurs frequently through many of the interviews, and was often accompanied by a pensive look, and reflective comments.

Although the women were allowed to tell their stories with encouragement but little direct interruption or intrusive questioning, we had conversations before the narrative was told, and again after they felt they had reached the end of their ‘story’. This time of ‘chatting’ was often up to 15 or 20 minutes before and after the story. Also I telephoned them all within the week following the interview to check out how they were feeling, and whether they wanted to talk further, or required any support.

### ***Was the verbal and written language used accessible and demystifying?***

I have attempted in written communications and during interviews to make the language accessible and demystifying. It seems inevitable, however, that calling for people to take part in an academic research project through written publicity immediately excludes people who find academia itself inaccessible and mystifying.

In summary, ethically I have tried to ensure that harm is minimised, that the participating women and their knowledge have been respected, and that the research has had an honourable purpose, and been conducted with a transparent and reflective process.

A particular ethical issue in Aotearoa New Zealand concerns the treaty which underpins relations between Māori, the indigenous people, and the Pākehā who have come to live in their country. The implications of this treaty for my research will now be discussed.

### **Te Tiriti o Waitangi**

The Royal Commission on Social Policy (1988) described the three principles of Te Tiriti o Waitangi (The Treaty of Waitangi) as partnership, participation and protection. The principle of partnership requires a commitment to mutual learning and power sharing between myself as a Pākehā researcher and Māori. I consulted with Māori colleagues as I was planning my research, some of whom were interested in participating. As a result I decided not to put any limitations on the ethnic identification of any women who wanted to take part, but to let people know in my first telephone conversation that I was Pākehā and to check whether they would like a person of the same ethnicity to interview them, or to be involved in the analysis of their narrative. The woman who participated and who identified as Māori did not want her narrative to be treated differently from those of other women. The findings will be available to Māori, especially through the woman who took part. I have already presented findings at conferences where Māori were part of the audience, and have had feedback that the narrative approach may make the work of interest to them.

The principles of participation and protection are compatible with the feminist ethical approach that has been discussed. It was appropriate to offer all participants, but especially those who were Māori the option of having Whanau (extended family) present at the interview, and I made this option easily available. None of the women chose to have others present as they told their story.

## ***Rigour***

Rice and Ezzy (1999) suggested that rigour in qualitative research can be considered under three headings: conceptual, procedural and interpretive rigour. Trustworthiness is another concept which has frequently been used in assessing the rigour of qualitative and critical research (e.g. Kincheloe & McLaren, 1994). Polkinghorne (1988) considered these issues specifically as they related to narrative research, and suggested that reliability relates to the “dependability of the data” and “validity to the strength of the analysis of the data” (p.176). Mary and Kenneth Gergen (2003) question the place of validity within a social constructionist or post modern understanding of the world. Trustworthiness may be a more useful concept, especially if it is applied to both procedure and interpretation. Moss (2004) acknowledged the close links between fidelity, ethical research practices and trustworthiness. The definition that evolved from her critical reflection is one that sits well with the research approach I have taken. “I define provisions of trustworthiness ... as acts of integrity that researchers take to ensure they seek truth by contextualizing their studies and disclosing all relevant procedures used in the study” (p.371). From her critical stance she adds to this provision for including marginalised points of view, and taking responsibility for social action that results from the study.

Crossley (2000) offers an approach to validity in narrative research which is less ‘critical’ than that of Moss, but also acknowledges the importance of the researcher recognising their involvement in their project. There is no expectation in this type of research to have neutrality or generalisability. Instead the research produces contextualised, information-rich data. She draws on the ideas of Polkinghorne (1988), and stresses the importance of narrative research being demonstrated to be “well grounded and supportable” (Crossley, 2000, p.104). The analysis needs to be explained, with an audit trail available. Findings need to be shown to be supported by data, including the use of verbatim quotations to support findings. The account of the research should be “comprehensive and coherent” (p.104). Aspects of my research that I have already discussed concerning the selection of participants, the analysis of data and the ethical issues all support the trustworthiness of this project.

Crossley (2000) proposes a further aspect of rigour: that the findings be “plausible” and “meaningful to both participants and peers” (p.105). This can be assessed by seeking feedback. I have explained in the ethical section how I have presented my findings to my peers, to many of the participants and to other people who

have overcome depression. The findings and my analysis and conclusions have been ‘meaningful’ and ‘plausible’ to these people. The group of five women participants and their contribution to the analysis are perhaps the strongest confirmation of the trustworthiness of this project. In the last weeks of completing the thesis a ‘final’ draft was read by one of the participants. She had offered to carry out this critical reading and her feedback was that she found the thesis, especially the Middle section very respectful of her story and that of other women participating. She was at times surprised by the sections of her narrative I had highlighted, but still found it true to her story. She particularly appreciated the emphasis that the data was a snapshot of her life, and that of the other women. She also really enjoyed the ‘narrative’ approach, and the idea that mine was one interpretation of many possible ones that would each be valid representations. She found the conclusions very interesting, and believed they resonated well with her own experiences, and those of women she knew who had lived with depression.

Decisions about the relevance of the findings to other groups can only be decided by the reader who has been provided with sufficient information about this group of women to decide how applicable the findings might be to another group of people in their particular geographical and historical context.

## ***Conclusion***

In this chapter I have described the major features of the research project in practice. The process of carrying out the project has been, for me, a fascinating one, and I have valued the opportunity to consider in a different way the kinds of stories I often hear in my counselling practice. As a researcher I have been able to spend many hours considering each of eighteen narratives, a luxury which never happens in clinical practice. I have listened and analysed and sought feedback from the women, but, in contrast to my work as a counsellor, I have not had permission to attempt to assist them through their journey. Nor should I have this role. Through the careful planning of participant selection, and interviewing, to the very insightful and respectful analysis by the five women in the group I have grown. I hope that the process has been respectful and ethical and that the ‘middle’ section of this thesis which follows, will represent in a trustworthy way the narratives I have been immersed in for the last six years.



# THE MIDDLE

The five chapters in this section present the findings. They offer my analysis of the eighteen narratives that are the core of the project. The thesis is about recovery, but these five chapters are about more than simply recovery. They reflect the way that the women told their recovery stories. The recovery was not told in isolation from the experiences of the worst times, nor from the women's understandings about how depression came to disrupt their lives. Thus the first chapter presents the women's worst experiences with depression, in the second I analyse their stories of why depression came into their lives. All the women talked about their resilience – the strengths and personal resources that endured through their lives and helped them to recover, and the third chapter is an analysis of these stories of enduring resourcefulness. The final two chapters in the section focus on recovery; Chapter Nine on the false starts, and the first moves beyond depression and Chapter Ten on the set of solutions that each woman found worked for her.

## Preamble to the Findings Chapters

The eighteen women who took part in this study had very different life experiences. At the time they told their stories the oldest woman, Hannah, was about seventy, and the youngest, Kate, was in her early thirties. Amongst the women there are many cultures, as well as many ages. Most have become professional women with some tertiary level education, although at the time their lives were disrupted by depression this was not the case. Some had very difficult childhoods, with frequent abuse, others talk of their childhood as joyful and happy. There are married women, divorced women, lesbian women, mothers, grandmothers and women without children. Some of these women are happily living in long term relationships, others tell of being very satisfied living without an intimate relationship. There are women whose favourite thing is to walk in the bush and others who would much prefer to curl up with a good book. The only feature which is apparent in all of them is their strength and determination, and the shared experience of having a life seriously disrupted by depression. Fuller introductions to each woman are included in Appendix F. In those introductions I offer a small taste of each woman's rich story and present something of their uniqueness without pre-empting the findings that will be presented in this section. I have made the introductions available because the analysis necessarily fragments the women's stories, and it is easy for the individuals to be lost in the grouping and distilling of their narratives.

The conventions that I have followed in presenting quotations from the women's transcribed narratives are relatively simple. In the body of the text, all the women's words are presented in *italics*. When I have omitted words from a quotation I have used three dots (...). When the woman has paused for a short time whilst speaking I have used a dash ( - ). The more dashes I have used the longer the pause. When there has been a very long pause I have noted this (pause). I have also noted when the woman has been tearful, excited, or thoughtful – these comments have been based on my interpretations of the woman's tone of voice and actions.

Each chapter is introduced by a poetic presentation of a selected part of one woman's story. This is followed by my commentary on that text indicating why I chose it, and some of my interpretation of its significance to the following analysis.

The first findings chapter bears witness to the worst times for the women – the seriously disrupted time/s which qualified them to be part of this project.

## Chapter Six: Disrupted Lives

### Charlotte's Disrupted Life

So,  
So when I stopped to have this baby  
I had no support.  
No. No.  
That's right.

And I was handed ....  
I had this child fast asleep.  
And that's when it got worse.  
Quite a bit. ....  
It's hard to even think.

And at its worst  
I couldn't sleep  
and so I'd be awake for a long time in the night.  
During the day ---  
I did the barest essentials.  
I washed the nappies  
and I bathed the baby  
and I washed the dishes  
and I cooked a meal  
at the end of the day.

And the rest of the time  
I was in a foetal position on the floor.

And ----  
I didn't know what to do.

It was all so grey.  
And I couldn't do anything.  
Any, any intelligent work  
I couldn't have done it.  
And, I don't think he knew how to deal with it either.

He didn't know how to,  
he didn't know how to cope with me.  
Or what had happened,  
or what had hit either of us,  
really.

We had no transport -----  
So,  
I was alone  
in the house most of the day.  
With nobody around.  
And to take a baby  
on the bus  
was,  
I mean, really very difficult.

So,  
I would walk up to Plunket ,  
and to the local shops  
which were about ten minutes walk away.  
And I would,  
I would not  
do anything else ....  
for about a year  
I suppose.

In this story of the worst disrupted year of her life Charlotte conveys the aloneness and the colourlessness of her experience. Her baby and her husband are included in the text, but at a distance, and without any meaningful connection. The ‘child’ is not *my baby*, it is *this child* she was *handed*. She carries out essential tasks, and in the list of nappies, baby, dishes and meal the baby assumes no particularly emotionally connected place in her life; it is there - along with the dishes, in the repetitive list of chores that need to be carried out before she can again assume her own place as ‘baby’ in a “*foetal position on the floor*”. Charlotte’s husband is there too, but involved only in the “grey” of her life – she is not able to “*do anything*” and he couldn’t “*deal with it either*”. They are both stunned, they don’t know anything. They don’t know how to cope, or what has hit them. So Charlotte just does the minimum to allow herself and her child to survive, and this disconnected, isolated, colourless life is not just a passing phase, it goes on for many months.

Charlotte reflected back over twenty years and recalled a life severely disrupted by depression. The transcription of her words into poetic form encouraged my “emotional engagement” (Kendall & Murray, 2004, p.70). What it omitted was that Charlotte spoke

with tears running down her face, and paused for long periods as she re-connected with her past suffering.

I focussed on this story within a story, attending to words and to their patterns, to Charlotte's voice and to the notes I wrote just after the interview. I was trying to understand better what it was like to live a disrupted life. At the same time I was aware that I could never understand fully. When Henry Greenspan (2003) talked to students about narrative research that focussed on stories of Holocaust survivors, he commented that "nothing is easier than to think we follow survivors when we do not: Nothing is easier than to mistake the tragedy recounted for the atrocity endured, the 'made story' for the 'whole story' " (p.103). In my analysis I have needed to be constantly mindful that the 'findings' are informed by the words of the participants, but created from my own standpoint. I am, however, bearing witness. Frank (1992) argued for social science researchers employing "a new kind of writing", a style differing from the "consistently dry, rational, medical model, analytical stance" (p.468). He urged researchers to "bear witness" to illness experiences in the way that they write, as well as the material they include in their research reports, to write about the nature of the illness experience as "embodied, angry, contingent, eccentric, interrelated and suffering" (p.483).

The women's stories of their worst times were full of passionate, moving and emotional language. They vividly recounted their despair and misery, even after a distance of several years. As they told their stories, many wept. They paused frequently during the telling. At times they sat silently, remembering and re-living. They then continued to talk about their vivid memories of those past times.

The women were qualified to take part in this study because their lives had been seriously disrupted by depression. They were not required to have had a 'professional' diagnosis of depression, yet by the end of this chapter, it may appear that they would all have qualified for a DSM diagnosis of 'major depression' (Appendix T). A diagnosis is a check-list, but stories tell much more. Their stories of these times have many features in common with the chaos stories that Frank (1995) writes about.

### ***Structure of this chapter***

In this chapter I analyse the stories of the most disrupted times. I firstly present the women's stories as they reflect features of a chaos narrative. I then explore the narratives in terms of the women's 'embodied' experiences. The relevance of other people in the women's lives at these worst times will then be discussed, and finally I

consider aspects of the stories which fit with Bruner's "landscapes of consciousness" (Bruner, 1987), including theories of depression, thoughts and spiritual or metaphysical elements.

### **'Chaos' stories**

Frank's (1995) categories of illness narratives (restitution, chaos and quest) were described in Chapter Four (p.80). The women's stories of the worst times have many qualities of Frank's 'chaos' narratives. Frank describes these stories as "chaotic in their absence of narrative order", they defy the expectation of a 'proper' life, in which "one event is expected to lead to another" (p.97). They are not easy to listen to because they reveal "vulnerability, futility and impotence" (p.97) and in many ways they are "anti-narrative" – stories without a beginning, middle or end. Frank suggests that these stories can only be told in retrospect (p.98) since at the time of their living the person is unable to achieve any "distance from her life and no reflective grasp on it" (p.98).

Most of the participants in my study talked of this worst time as one without hope, and they all conveyed a sense of a great depth of misery and hopelessness. Frank (1995) describes one woman's chaos story as having "no narrative sequence, only an incessant present with no memorable past and no future worth anticipating" (p.99). Her 'troubles' were "incessant", and went "all the way down to bottomless depths" (p.99). These aspects of 'chaos' stories are strong features of the 'disrupted lives' stories within the women's narratives. Most contain a lack of sequence, and focus on the random and repetitive happenings of this worst time.

### **And then, and then, and then -**

When Frank discussed a woman's story, and how it featured an "incessant present" he talked about the "syntactic structure" of "and then and then and then" describing the talk as a "staccato pacing of words" which "peck away at the reader just as the woman's life pecks away at her" (Frank, 1995, p.99). Charlotte's story is one example of such 'pecking', and many other women display this 'chaotic' feature in their stories. The repetition is evident both in the manner of the telling, and in the life events the women talk about. Anne describes her life at this time as being full of "*compulsive activity*". Christine became "*obsessed with cleaning*", describing her need to clean every corner of her house during and after her pregnancy. She uses the "staccato" talk to describe her obsessive cleaning; "*the only way of getting around that [the anxiety] was to ... clean your whole house, and do it, and do it, and do it.*" She also became

obsessive about her baby's breathing. She would sit by the cot, "*sit there **most of the day, and most of the night, most of the day**, with my hand on her*". Away from the child she engaged in meaningless activity, she "*walked and walked and walked*" because she "*had nothing else to do*".

Chloe's worst times were "*bleak*" and filled with bad relationships, alcohol, binge eating and unsatisfactory work experiences. Her talk of these times is a 'chaos' story characterised by bleakness, a lack of sequence and no sense of hope for the future. It was a life of bare existence, presented in a 'staccato' way.

*I really went off the edge then. I became increasingly unstable in myself – **and** drinking, **and then** I got caught for drinking and driving. **And** I lost my licence for six months, **and** I just felt like a really bad person – **and** work was very poorly paid – **and** I'd accepted a job that was so poorly paid –..... Life was very bleak – for most of my twenties - like a bit of a blank where I just existed I think – and barely, barely.....*

For Chloe this chaotic time of her life lasted for over a decade.

Katy's times of disruption were briefer. Although she did not speak in a staccato way, she talked of her struggle to carry out relentless, disordered activities; activities she needed uncharacteristically to force herself to do:

*I just couldn't get back on my feet again. I would be waking up in the morning and thinking, cause I live on a little small holding – so I've got chickens and ducks and turkeys and sheep and goats and dogs and cats and pigeons, you name it, I've got it, plus all these kids as well – I'm quite ..... And, ummm ....., so I had to get up and struggle to get out of bed in the morning and force myself to go down and deal with the animals, and come back, and have to sit down and think, well, what do I do now? Well I suppose I had better do the dishes .... And this went on for weeks and weeks and weeks.*

These five women's stories represent all eighteen. The sense of mindless, repetitive activity pervades many of the stories of disruption. Embedded in their 'staccato' telling is a sense of bewilderment, and of the meaningless nature of existence at this time. One of the disruptions of depression is that it removes a sense of purposefulness, a sense of order, and a sense of hope from day to day life.

### **No future worth anticipating**

At their worst times, none of the women looked hopefully towards their future. The clearest indication of this hopelessness was talk about suicide. When the women were in the midst of 'chaos', believing that they had no future worth anticipating, and while

they were experiencing the “bottomless depths” of despair and depression, twelve of them seriously contemplated or planned suicide and some tried to end their own lives. Of the six who did not think of committing suicide, Elizabeth, Fiona and Kate never mentioned thoughts of self-harm, although Elizabeth was very conscious of her discovery, as an adult, that her father had committed suicide. Kay and Charlotte specifically stated that they did not ever consider suicide, although Kay was surprised that she hadn’t. Ruth was ambivalent. She said that she often contemplated metaphysical issues of life and death, and wondered “*what is the point of being here?*”, but she also said :

*I haven’t tried to commit suicide, I haven’t planned suicide, but there’ve been times when I’ve wanted just to die and go somewhere else. And, I don’t of course .....*

### **Suicide**

The twelve remaining women all recalled having thoughts about suicide. Many had clear plans to kill themselves, plans which were not completed, either because they were prevented at a particular time by someone else, or more often, because they stopped themselves when they thought of the impact their action would have on people who were important to them.

The women were not, however, always clear about what stopped them. Anne, for example, when she was a young adult, lived with suicide as an ongoing possibility:

*At one of those points I would have either been dead or I would have been institutionalized. Neither of which quite happened but were pretty close ---- um ---- via sleeping pills. ... I lived with enough to do it, and it was on my mantelpiece and that was the first thing I saw every morning and every morning it was – “is it going to be that or not?” – or “am I going to Art School?” and some – I don’t know what it was that got me to Art School every day. Just not being quite close enough to being taken – being overwhelmed by it – just enough of me present to – or enough of me hopped into my work perhaps at Art School. I don’t know. I don’t know. At the time it was an inevitability. I was going to take those. And I’d gone to quite a lot of trouble to make sure I had enough and the mantelpiece – the fireplace – was in my bedroom. So it was right by my bed and because I woke up with searing pain that I went to sleep with. And it was that terrible thing of I just can’t face another day of the screaming. It gets louder and more desperate. And it would have been just an inevitability that sooner or later I would have – I would’ve taken the pills, – it had reached the point where I just couldn’t bear it anymore.*



Later in her life the thought of her children interrupted her plans:

*...the older I got and the more, the more grief and the more loss of hope ... The dilemma was that I had kids that time. That stalled me to some extent – I was together enough to know I would be inflicting it – they only had each other, and I had three sisters ---*

Through the despair and hopelessness Anne recalled that she stayed alive because she was aware of the impact her death would have on her children.

Isobel and Christine, however, both talked of reaching a point where they believed their children would be better off without them. Isobel's husband had recently left her, and she drove the three children to the place he was living and said: *"They're yours. I'm off. I'm going. I'm not coming back. They're yours."* She then drove hundreds of kilometres to a place where she planned to drown herself. She recalled this crisis, saying:

*I didn't tell him where I was going and I remember standing at the top ... and thinking "I just wish I could jump off. I wish I could." And I didn't care about the kids. That was the scary thing. I actually didn't care about the kids.*

Isobel then told of how she stood, wishing for death, but then found her thinking following a different path. She remembered that she had frequently criticised her husband for leaving the children. She had yelled at him *"You might have left me but don't you dare leave your kids. You've got to work harder at this"*. When she realised she was standing there *"willing to give away my kids"* and *"not care"* she thought *"this is crazy"* – and went back to her home city and her children.

This was not the last attempt for Isobel. Some time later she again reached the point where life did not seem worth living, and on this occasion took *"a nice cocktail of pills, anything I could find in the house"*. She now feels fortunate that she was not at the time in her own home, where she had accumulated enough antidepressants to form a lethal dose. Instead she finished up in hospital, having her stomach pumped, because her ex-husband walked in and found her as she was *"finishing this glass off of god knows what"*.

Some of the women made just one clear attempt to end their own life. These single incidents were usually triggered by a particularly desperate feeling in the midst of a time of despair. Hannah was taking a friend home and was then intending to *"slam"* her car *"into the overhead bridge on the motorway"*. Her friend sensed this was going to happen and refused to get out of the car. Hannah had reached her *"lowest*

ever” point, and at the same time felt her “*most courageous*” and was clear that she had “*decided I was going to commit suicide*”, because she believed she “*had betrayed everything*” and “*oblivion was the answer*”. Only the refusal of the friend to leave the car prevented her carrying out her plan.

Katy also had very specific plans, which would have been to “*hang herself in the bush*” or to “*jump off a cliff*”. For her, the thought of any of her children finding her “*like that*” stopped her from acting on what she said were “*very, very serious thoughts*” about suicide. Thoughts of family members also prevented Karen from carrying out her plan of drinking down “*a ton*” of “*paint stripper or something*”. She thought of her love of her mother and her mother’s love for her. She knew her mother would be absolutely distraught, and so she couldn’t do it. Hine talked of often feeling suicidal, when she would “*get to the bottom*” where she felt “*there was nowhere else to go*”.

Christine’s single serious plan was triggered by a very specific set of events. She discovered she had an unplanned pregnancy. She had had a terrible experience of depression before and after the birth of her first child. Feeling that she could not face this distress again she begged her doctor for an abortion. When this was refused Christine felt she had reached “*rock bottom*” and decided “*I am going to go out into that lake and kill myself*”. She said no more about this thought, but had clearly planned to end her life. Linda, in contrast, did not mention any particular plan, but acknowledged that she was at times “*suicidally low*” although she “*didn’t want to have to finish myself off*”. It is as though in their recollections these women battled with the idea of suicide – as though it took them over against their wishes and intentions. They all reached a point when as Linda said “*I couldn’t bear the thought of having to get through another day*”. A thought which was echoed in Marge’s statement that she was “*just wanting to die*” and that she couldn’t “*imagine getting through any more of my life*”.

Chloe, like Isobel, made a serious suicide attempt. She took a whole bottle of pills when she reached a point where she “*just couldn’t cope*” and she “*couldn’t see how it could change, how it could get better*”. She never tried suicide again in the same direct way, but believed that her continued heavy drinking of alcohol was “*doing it in another way*”. Naomi also considered that her long term involvement with smoking cigarettes was a “*real sign of something, some sort of self hate*”. Even before she took up smoking, Naomi reflected that she often contemplated suicide. She remembers thinking of killing herself when she was a child:

*.... I used to stand at the edge of windows in high buildings, and think about throwing myself off. And I can't tell you now, why I was doing that. ....But I remember doing it. I remember thinking about it. And it had, it had to do with a, with a, with an empty pit, you know, inside. A .. a .. a .. a void of some, of something or other.*

Jane took risks with life and death, but more directly, and over a much shorter period of time. At the time when her life was most disrupted by depression she talked about “*driving on the motorway recklessly, without even thinking about what I was doing. I had three very near misses, ---- where I had to screech to a halt--*”. Jane’s behaviour and that of the other women seem to be part of their response to what had become a meaningless life.

### ***A meaningless life***

Even when the women were not actively suicidal, many expressed the overwhelming sense that life was meaningless. At her worst times Christine was encouraged by friends and family to take some time for herself, but she found that she “*couldn't think of anything I wanted to do*”.

Kate spent most of her twenties “*smoking a lot of grass*”, sleeping and feeling unable to leave the house without her partner. She describes her life at this time:

*I would sleep, you know, twelve hours without any hassle. I found that was a good blocker. I, um I didn't want J (her partner) to touch me at all. Our sex life was just non-existent. And -- yeah -- wandering. I found myself pacing up and down in the house, because I couldn't go out. I couldn't get rid of that excess energy. And just the whole feeling of -- I couldn't do anything. I wasn't in control of anything, I couldn't -- I had to ask permission -- to -- umm do anything. And so therefore I did nothing.*

Most of the women refer quite explicitly to the meaningless nature of their life at this worst time. Here are some of the clearest examples of that pervasive sense of the meaninglessness of life.

**Isobel:** *I just had no meaning in my life.*

**Jane:** *I was crying and calling out to God, and saying “I need your help, if you're there”.*

**Kate:** *...feeling like there was no point to my life.*

**Katy:** *I felt like there was just no point in getting up in the morning.*

**Linda:** *I felt really, really low and powerless to do anything.*

**Marge:** *I don't want to go on, I can't bear to think of me spending the rest of my life on this earth. And --- wishing I'd never been born. I can't think of any options.*

**Hine:** *No hope, no choice, nothing to look forward to, no happiness.*

**Ruth:** *I've thought, what's my purpose? I mean what's the point of being here? I mean what's going on?*

### **The bottomless depths**

The metaphors that the women used concerning their disrupted lives are rich and powerful, as is their descriptive language generally. This was particularly so when they tried to convey the bottomless depths of their worst times. Hannah used a metaphor that connects closely with Frank's phrase. She talked about being at her "lowest" as going "*down and down and down*" into "*a complete, umm, abyss, of total blackness, and I just had nowhere to go. There was nowhere to run, nowhere to go. There wasn't anybody I felt that would understand or I could talk with or reach out to.*" Isobel used similar imagery when she said that she "*just went down into a great big sort of void*". Karen recalled one of her worst times when she felt "*my whole bloody life is going down the tubes*". For Hine depression was "*about being in a tunnel that you can't see the end of*".

Anne talked of her many years of being "*robotic*", and living with a sense of "*futility*", but the very worst times were times of "*screaming*" and "*terror*". She said;

*I lived in a blank world all the time – Yeah. I just lived a life of grey all the time, but when there was an emotional crisis --- it was screaming..... the pain that I'm feeling, the terror and everything else is bigger than the situation – its like a snowball that gets bigger every time I have a massive episode, and so the screaming gets more louder and more desperate....*

Amongst the screaming and the terror, Anne talked of her "*life of grey*" and others talked of depression as '*colourless*' or '*misty*'. For a different group of four women this worst time is associated with blackness. Perhaps these particular images of a lack of colour and darkness are the ones most readily available in our Western Society in talk about depression. The depths also included low self-worth, often accompanied by a deep sense of shame, not only about who they were, but also about '*being depressed*'.

### **"My self esteem crashed"**

For Fiona the worst time was pervaded throughout by a devastating loss of self-esteem. A feeling that she "*wasn't good enough*", and wasn't "*effective in the world*", that she was "*just stupid*" and "*not even ornamental*". The bottomless depths for nearly all the women involved this extremely low self-esteem. Elizabeth describes it as a time when she reverts to her basic "*personality type*" which is to "*look for all the reasons why I am to blame*". Linda talks of being "*emotionally wrung out, and in a bleak situation*"

where she knew that her *“level of self-like, or self-love was pretty low”* and her self was *“just crumbling”*.

Naomi recalled her fear that she would *“never live up to anything”* and then remembered going *“to a place of failure”* and *“self-defeat”*. This stopped her achieving, especially at work, and this had a negative impact on her *“esteem”* which she considers you *“get from your work”*. Your identity was somehow *“enconched in it”*. Anne did not limit her sense of worthlessness to any one situation. She felt she was *“fundamentally flawed”*. Chloe, at her worst, believed herself to be *“a bad person”* and had no *“confidence”* and no *“respect”* for herself. She now knows that at this worst time she was *“hugely judgemental”* about herself, and was *“tormented to the point of just desperation”*. Kate believed that *“badness”* was her *“natural state”* and that she was *“totally unworthy of everything”* and *“utterly worthless”*.

The sense of being worthless was made even worse by the shame and stigma of being ‘depressed’. Linda’s depression was intertwined with anxiety for a lot of her life, and she may have been absorbing the stigma of society when she talked of both these distressing feelings as *“shameful”*. Marge struggled with feeling she was *“never good enough”* especially in work situations, and found that *“out in the world”* she was afraid of criticism and of failure, and *“embarrassed”* about being depressed. When she recalled these feelings she said that this was when she *“got to the bottom”*.

### **The chaos of a life disrupted by depression**

The women’s stories show how chaotic their lives became when depression was most disruptive. The chaos could last a few months, or more than a decade, disrupting lives which were potentially meaningful and ordered. The chaos impacted on many aspects of their day to day existence. I will now discuss the predominant experiences. Aspects related to embodiment and to the significant but supporting roles played by other people are the major areas which emerged. I will end by considering some features of the language that women used to describe their lives during these despairing and extremely distressful times.

### ***Bodily Experiences***

The women often referred to the body and its actions, making the holistic nature of the experience clear. For some, like Anne, this bodily experience included frenetic activity, but for most it involved a slowing down and a limitation on what their bodies would do.

The experiences are complex but in this section the quotations have *action* foregrounded.

All but two of the women talk very specifically about the worst times as being experienced directly in what they *do* - their body and its actions. Their stories support Bruner's assertion (1990) that "saying and doing represent a functionally inseparable unit in a culturally oriented psychology" (p.19). As the women constructed their lives through narratives, they were constructing an embodied life. Naomi referred to her body frequently, and said "*the physical thing is really important somehow*".

The most powerful image that emerges from the narratives is that of a woman curled up in a foetal position, not at night in bed, but during the day, on the floor. I will start this section with some of these graphic descriptions.

### **Curled up in a Foetal Position**

In the introduction to this chapter Charlotte tells of being curled up most of every day in a foetal position, and this was a common experience for many women in this study. The language and the image of returning to the womb is powerful. Naomi spent "*days curled up in bed*", as did Ruth. Fiona curled up on the floor, and at times was so low that she felt she was "*in the earth under the floor*". Hannah said "*I just slept in a foetal position, and I never made a bed, I never did anything*". Katy found that:

*every spare minute I'd go into the bedroom and I'd curl up in the foetal position, and I don't cry very easily – so I wasn't crying, but I felt as if I'd got this huge mound of tears in me...*

Whilst Kate did not mention the foetal position she told of crying out to her partner "*Don't touch me, don't touch me, don't touch me*" and then she said "*I found myself in the corner of the kitchen, kind of not cowering, but trying to hide*." Having related this story very emotionally she then became more reflective and recalled:

*--- sometimes he would leave the house, and I would just go and find a corner. And go and curl up in a corner and cry. I would get up in the mornings, and I'd get into the shower and I would cry in the shower, because I figured he wouldn't be able to hear me in the shower. It was just the thought of another day.*

Kate described her partner as very supportive and gentle, and throughout her narrative he is presented as loving and kind with never any suggestion of threat or violence. She was not hiding from him, or reacting to him. As she said, her reaction was to "*the thought of another day*".

When the women were not curled up and immobile, the pace of their lives was often disrupted by depression.

### **Living life at a different pace and in a changing body**

Anne described “*frenetic compulsive activity*” along with an inability to eat, and a weight loss which took her down to six stone, and reduced her to a state where she was “*scarily low in resource*” and where her “*hair was falling out*”. Like Anne, Isobel suddenly lost a lot of weight, “*about 18 kilos*” when she was in her “*most desperate state*”. Jane quickly lost 10 kilos.

In contrast to the experience of hyperactivity, many women described numbness. Fiona had days where she “*just couldn’t move*”, and sat around and cried, “*just really numb*”. Christine talked of being a “*robot*” and a “*zombie*”. She said “*I couldn’t, I couldn’t speak. I honestly – I couldn’t speak. I couldn’t move. I was a zombie.*” Naomi also used the word zombie. She said that she “*had a numbness - you know, the zombie*”. She elaborated on this state, saying:

*For weeks on end I had the phone off, and getting up in the morning, and couldn’t start. Started to have this thing where I couldn’t actually dress myself. Couldn’t even find stuff to wear. Hated my, hated myself so much that I, you know, I couldn’t clean the house. Couldn’t cook dinner properly. I was really, I was really struggling badly, you know.*

Almost half of the women talked about the slowing down of everything their body did. Fiona’s whole body became “*immobilised*” and she could “*hardly breathe in and out*”. Kay described how things that were usually ‘normal’ became “*an incredible hassle*”:

*One afternoon I was in my dressing gown, in the hallway, surrounded. Sitting on the floor, surrounded by a vacuum cleaner that I was trying to put together to vacuum the house. And just thinking – oh this is so bloody awful. This is --- oh God --- dreadful, why didn’t I get another dog. Instead of a baby---*

Kay, also was “*immobilised*” in relation to self care. Her husband had to say “*Get in the shower, shampoo and condition your hair, here’s some nice talcum powder, use this*”.

Jane, as well as losing weight very quickly, experienced a marked slowing down:

*I think the thing that really made me stop and take ---- was it took me two hours to do my grocery shopping. I used to enjoy my grocery shopping, here I was taking two hours going round the shopping centre, and I couldn’t make decisions. Couldn’t walk any faster.*

For many women this disturbance to the pace of life also involved their sleeping patterns.

### **Disturbed Sleep**

The DSM recognises a change in sleep patterns as a common symptom associated with the diagnosis of depression. Many women in this study had sleep difficulties. Charlotte said *“I couldn’t sleep and so I’d be awake for a long time in the night”* and this resulted in a *“fear”* that she *“wouldn’t be able to sleep”*. Linda’s many physical difficulties were exacerbated by her *“inability to sleep”*, while Chloe went for years without being able to *“sleep through the night”*, instead she would *“wake up tormented”*. At times she used alcohol to try to achieve a night of sleep. Christine had *“trouble sleeping”* over many years, and Hannah recognised her second bout of depression because she *“wasn’t sleeping”*. Jane, at the very worst time *“wasn’t sleeping”* and it was taking her *“two hours to get to sleep”* and then she would wake up again at 4am. She said she was *“surviving on three hours a night for month after month after month”*.

Kate, Katy, Marge and Ruth experienced the other extreme of sleep difficulties. In her late teens Kate wanted *“to spend the whole weekend in bed”* and looking back she saw this as a sign of depression, rather than the *“teenage behaviour”* it was judged to be by friends and family. Katy, who has been for most of her life, an extremely physically active woman, with little need for sleep, found that at her worst times she *“wanted to sleep for twelve or thirteen hours”*. Ruth *“had a lot of sleeping”* which she tried to explain away by saying she needed the energy to do everything else in her life. However, in retrospect she saw it as a symptom of her *“depression”* and a reaction to the unhappiness of her marriage, and to her *“needs not being met”*. Marge too spent much of her worst time in bed, saying:

*most of the time I wasn’t working I spent in bed, basically. With just really black thoughts and crying all the time, and it was, it was really, really bad.*

Naomi spent days *“curled up in bed. I just couldn’t face the world”*. The women’s bodies revealed their distress in a number of ways, and for some it was through pain and illness.

### **Physical illness**

The women talked about their bodies manifesting depression in very specific ways. Chloe and Ruth believed that some of the bodily pain and distress they experienced was



connected with depression. Chloe said *“I think it [depression] manifested itself in a few physical ailments throughout my [life] – particularly in my adolescent years”*. She had scarlet fever and protracted bouts of tonsillitis. Kate said that she considered a flaring up of pain in her neck and shoulder as a *“really big signpost”* that *“tied in”* to *“bad mood swings”*.

Kate also experienced *“fuzzy vision”* which she saw as *“quite a classic sign of depression”*. She recalled with a wry, sad humour some of the ways that being *“fogged up”* by depression impacted on her behaviour and wellbeing.

*...eventually you are fogged up. You can't see. I mean I've had days where I really actually pissed out of the window. And you can't focus. .... You really can't see. You know it's a bird on the tree, but you can't quite pinpoint it.*

Karen and Linda both include embodiment as a major part of their entire narratives. Karen has had a progressive and deteriorating disabling condition throughout her life, and this condition interweaves itself throughout her story. Linda had physical symptoms which were seen as psychosomatic by professionals involved in her diagnosis and treatment. Her story of the worst disruption includes references to physical complaints such as *“searing neck pains”*, constant headaches, *“irritable bowel syndrome”*, and *“physical exhaustion”*. She says: *“I carried a lot of body pain that never seemed to go away”*. Central to Linda's whole story was the extreme painfulness she experienced when she had sexual intercourse. As her story unfolded it became apparent that her narrative is the closest to Frank's 'chaos' stories, because for her the chaos came out of her physical difficulties, which were repetitive and unrelenting.

The next major section of this chapter explores the place of other people in the women's lives at these times of disruption. Interactions with professionals were central to Linda's distressful journey. Many of the other women also interacted with professionals during these hard times, but the full stories of these encounters will be included in a later chapter about the search for solutions. Here I will consider the people who were witnesses to the disruption, and the roles they played in the women's lives at these times.

### ***The Role of Other People***

In the worst times the women were at the centre of their own narratives of distress. There were loving people close to some of the women, as with Charlotte and her baby and husband, but the potential connection was somehow not experienced at these worst

times. Other people were supporting actors, and often recognised as caring deeply and behaving in loving ways, but they were unable to relieve the pain.

It was pointed out by Bruner (1990) that physical pain can “obliterate our connection with the personal-cultural world and wipe out the meaningful context that gives direction to our hopes and strivings” (p.22). Whilst she wrote of extreme situations of torture, it is apparent from the women’s narratives in this study that the severe distress of depression is intertwined with a sense of disconnectedness with other individuals and with a meaningful place in the world. It is not that these women were without the presence of other people in their lives, indeed, many of them had very loving, concerned and supportive partners, family members or friends. In later chapters I will tell more about the significance of these supportive people in the journey beyond the place of disruption. At this stage they are more on the sideline as witnesses to extreme distress.

### **Profound aloneness: “I don’t want to see anybody”**

In the analytic process it became apparent that every story about the worst disruption involved a lack of intimate, meaningful connection. The recurring image of the women curled up in a foetal position on the floor evokes isolation and a lack of direct communication. It also involves ideas of vulnerability, powerlessness, and the restricted landscape within which the woman/foetus lives. This disconnectedness was conveyed in stories within stories and in metaphors. It lasted for varying lengths of time, and was for some women a one off, single period of their life, but for other women it persisted for years or kept returning.

The women talked of this worst disruption of their lives as a time of crying out into a void, living a robotic life in a grey landscape, hidden behind masks, unable to connect even with people who loved them. Potential connections were either avoided, or not experienced as making any difference to the sense of aloneness. Anne graphically described this feeling “*peripheral, like a satellite that couldn’t quite land, that just went round and round in circles, but never quite landing*”.

### ***Available others***

Charlotte talked about her baby and her husband in a disconnected way. Christine was so worried about her first born baby that she reached a point where she felt she could not bear to be with her. She would wait anxiously at the gate for her husband to come home from work “*to give her to him, get her away from me*”. When she had her second

child, whom she had tried to have aborted, she was “*so detached*”. She described with real sadness, how it had been when she took him home:

*... when I brought him home it was just like. I could shut the door on him. He cried. He did this, he did that, I just shut the door. Whether it was --- in the end, you know, I'd sort of leave him alone.*

Kate never had children, and she pushed her loving partner away during her worst times. She also felt unable to connect with people whom at the time of the interview she could describe as “*really lovely, really good to me*”. At the worst times she recalled “*I couldn't tell myself that they liked me because of me – I felt they were doing it because they were that kind of people, or because they felt sorry for my partner*”. She realised later that she “*didn't allow [herself] to have friends*”.

### ***Isolating oneself***

One significant aspect of ‘aloneness’ that emerges from many of the narratives is the deliberateness of the isolation. Some women did not accept connections with people who cared about them. Many of the women consciously organised their lives so this reaching out was not even possible. They created a physical or psychological space where they were apart from other people. Kay described herself at this time as being “*resistant*”, “*resentful*” and “*not approachable*”. This separation was not because they felt others did not want them, nor because they were being badly treated. There is more a sense of being quite unable to bear the thought of being with others, even those who were very loving. Kate included a very graphic small story within her narrative. She talked about her attendance at massage classes, which became increasingly difficult as depression came to disrupt her life. She said:

*It was just such a strain. I remember starting to feel sick about going there...like physically sick in the car. And one day I came home, and I was so up tight about having, touching people in the class that I'd stopped doing it. They were all very understanding about it. But .....*

Anne made a decision to be alone, and talked of how she managed her life to let this happen, even though she sacrificed her love of painting. At one of her worst times she was studying at Art School and she chose to study photography rather than painting because of the dark-room.

*What I needed was a space where nobody would come in and say “Oh, how are you getting on Anne?” .... I could lock the door. So I spend three of my four years at Art School in my darkroom – my little personal dark room with a closed door.*

Chloe also isolated herself whenever possible. When she needed to be in the public gaze she was ‘masked’, but whenever it was possible she “*hid a lot of it behind drink and behind closed doors*”. She “*didn’t want anybody to visit*” and just “*hid out at home*”. Naomi chose to live in an isolated community, where it was difficult to stay in touch with people. She created a place of isolation for herself which she described as “*my little womb*”, a metaphor which linked with the talk of being ‘curled up in a foetal position’. Naomi reinforced this physical isolation by taking her phone off the hook for weeks on end.

Elizabeth took extreme action to isolate herself from her family and everybody she knew. She left her husband and children and went to France where she spent six months. I will write more about this decision in a later chapter, but initially it was a way Elizabeth found to be profoundly alone. She said “*I wanted to escape. I had to go. There were no two ways about what was happening. I just had to get completely out.*” This response was not to an unhappy or unloving situation, but from the midst of a happy family, whom she returned to, and is still with more than a decade later. Elizabeth offered some explanation of this chosen isolation. She said “*one of the big things about depression to start with is its --- its not only not being able to name, but it’s the isolation. Its like I’m the only person that feels this way.*”

Hannah, like Elizabeth, felt unable to stay with her children, and also travelled away from them and her husband to the other side of the world, to her own mother and siblings. She commented that at this time when she was at her “*lowest, suicidal, ebb*” she “*didn’t even think about my children*”. She created a mental and social equivalent of Anne’s dark room, which she described as her “*own brick wall*”. This wall was erected “*so nobody would have got through*”. Hannah never returned to the marriage, which was not happy and supportive as Elizabeth’s was. However, she did return to care for and grow loving relationships with her children.

Other women also found that one of the worst disruptions of this time was the distancing from their children. Isobel recalled that she “*didn’t care about the kids*”. Chloe had children in her thirties, and they were very much wanted by both her and her partner. Nevertheless, when her children were born she was in one of her worst experiences of depression and she found that she “*really didn’t want this child*”. She remembered with great sadness that at that time “*I’d watch other people loving her, and I knew I couldn’t. I knew I did, but I couldn’t.*”

### ***Living behind a mask***

Many of the women used the image of a ‘mask’. Chloe said she was “*a mask walking around*” and “*struggling inside*” – suggesting that what the outside world could see was in no way representative of her inner turmoil. She talked of there being “*two Chloes*”, the masked one that everybody saw, and the other one who was only seen by her husband and her brother. Naomi came to recognise that as a child she was seriously depressed, but nobody could notice because it was “*masked*”. By the time of the interview she realised that “*everybody thought I was just this, you know, really happy, popular, girl*”, but she knew she was thinking of jumping off high buildings. One of Naomi’s masks was a “*happy*” mask, but another concurred with her family’s message that she should not “*be happy*” and she described that as her “*no expression mask*”. Kate recognised the potential of a masked and a visible self, but was glad she didn’t need to use the mask, since she never left home during her worst times. Only her partner, “*poor J*” was affected, but at least she did not have “*to maintain a sanity front*”.

Another aspect of living behind a mask was revealed when the women talked about continuing to work, even though they were feeling desperate. Chloe managed to continue working, even at her worst times and offered some insights into why she could do this. She was very emotional as she told this part of her story, explaining why it was easier to continue to work in her profession than to be a mother:

*Oh yes, Oh God, yes! Being a mother meant I had to be sort of emotional and I just didn’t want to go there. So. I raced back to work and that was very helpful. And my mother-in-law took over the mothering role with my daughter. Thank God (whispered) because I wasn’t able to do it.*

Hannah could not even manage to be with her young children, but she said; “*I never did anything. Except I worked, I went to work.*” She talked about having a protective “*veneer*” when she was at work. When, many years later, her husband experienced depression she had insight that helped her understand his search for isolation. He would “*go to the toilet and sit and cry*”. She explained from her own experience:

*because it was the one place where you could not put up the brick wall. You could pretend and make yourself busy everywhere else, but in the toilet you couldn’t. That was the one area where it just came, welled up, and it was allowed to spill out.*

Fiona also hid her desperation when she went into the world. She created her own mask of respectability: “*the middle-class lady thing. On goes the make-up, on goes*

*the earrings, put the hair back, on go the heels and the nice jacket, and off into the world you go. And you're just a shell.*" But behind this 'shell' she was "*just devastated*". Earlier she had talked about "*battening down*" her own "*hatches*", and at another time she described herself as "*just a mask*". Linda also went on working through the worst times, "*driving myself like a whip*". She believed that working and not telling anyone there what was happening was part of her survival. That "*if I started off loading onto people I'm never going to cope*".

The strong symbols of walls, battening down hatches and shells, speak of the women's need to protect themselves and to put a strong barrier between themselves and the rest of the world in these tough circumstances. The women also suggested that the mask enabled them to avoid too much contact with their own painful emotions. Sometimes, however, the emotions overwhelmed them, and the women acted out against the other people in their lives.

### ***Acting against others***

The strongest messages given by the women were that they withdrew, hid behind masks and were disconnected. Occasionally however they were more actively rejecting or angry. I have already referred to this when Kate shouted to her partner to leave her alone, and Christine actively rejected her second child when he was born. Hannah retold, with great sadness, that she had realised how badly her life was affected by depression when she became angry with her infant son. A bottle of milk had slipped from his hand and spilt all over the floor, and she told how she over reacted: "*I really lost my cool, and I really, I hit him.*" Not long after this she left her children with her husband and travelled back to the other side of the world without any of them. It was some months before she felt able to come back and reconnect with the children.

Where the women felt that some other person, such as a husband's lover, had brought on their misery, they at times became really angry. On reflection they saw some of their behaviour then as "*stupid*", or "*silly*". Isobel, for example, talked of ringing "*the lover*" in the middle of the night, or parking across her driveway blocking her exit, and shouting at her. Isobel said that she was not proud of this behaviour, but at this worst time it continued over a period of weeks.

### **The reactions of others**

Many of the women reflected on how other people reacted to them at this most disrupted time of their lives. On the whole the women were the central characters in

their own lives at this time. Most of their ‘disrupted life’ narratives were very focussed on how life was for them, and other people were presented mostly as ‘supporting cast’. Sometimes this support role was positive and sometimes it was negative, but a lot of the time these ‘others’ are described as bewildered, as not being able to understand.

### ***Receiving support from significant others***

Many of the women had people close to them who were willing, and at times able, to offer appropriate support. Hannah talked about her husband not being able to cope but later in her story she talks of the importance of his taking her out for a walk at weekends, and that her return home was like “*going back to prison*”. Kate’s partner offered similar support. She said “*I wouldn’t drive to the supermarket, my partner and I did everything together.*” Marge mentioned her partner a number of times throughout her narrative and always as a very positive influence. When Marge was at her worst she had to stop work, became financially dependent on her partner and slept a lot. Marge explained how her partner responded to this situation:

*So, for a long time, you know, I would, you know, in the afternoon I’d just have a lie down and go to sleep, you know. And she never had a problem. She didn’t come home and say “You’ve been home all day, why haven’t you done the dishes?” (laughs) You know, she’s not that kind, not that kind of person at all. She’s totally supportive of whatever I .....*

### ***The impotence of willing others***

Some of the most loving people in the women’s lives were unable to understand, or to find ways to help. For example, although Charlotte talked of her husband’s inability to “*cope*” with her, she also described him as “*sympathetic*”, but remembered that he would often just “*go out and dig the garden*”, even when it didn’t need digging, because he didn’t know how to help her. In one of Chloe’s later episodes of depression she was with a loving husband and soul mate. However, he too, was impotent in the face of her depression. “*He didn’t want to hear of it [the depression]. He didn’t want me to be thinking those thoughts while I was carrying a baby in case it affected the baby.*” Elizabeth’s husband was also unable to understand, although, as will be seen in a later chapter, he played a crucial support role in the solution that finally helped her to move beyond depression.

Hannah described this sense of people who were willing but powerless, in relation to a close friend. She recalled this person talking with her when she had recovered:

*My friend said to me "Hannah, I was so worried about you. When I rang you that day and you said "Yes, I'm fine." I thought - she's in such a terrible state." But she said "I never came and saw you or did anything more, because I didn't know what to do."*

### **Negative 'supporting actors'**

Not all family and friends were warm, sympathetic or willing. Chloe, for example, talked about the supportive attitude of her husband and his mother, but when I asked her about her own mother, she smiled ruefully at me, and said "*Wouldn't have a clue. Still wouldn't have a clue.*" Karen recalled a time when she was in her teens, and experiencing serious depression. She remembered that at the time her family and her teachers told her to "*just get on with it. Don't make a fuss*". Linda's experience as a young adult was similar. As she thought back to that time she said she can understand that "*people can be very unkind to depressants*" because "*you're so awful to be with, why would you want to be with you?*"

Hine felt that other people, including her family, "*slotted her into a little box*" of being "*a depressive*" and that they saw her as a "*loser*". She told me she had got the label in her family of "*being somebody that was kind of mentally and emotionally unwell a lot and was a bit loopy and not quite right*" and wryly described this attitude as not "*really helpful*".

Relationships during these worst times are complex. People are present in many of the stories, but in a variety of roles, and with mixed impact. None, however, are able to take away the pain and distress. This pain pervades all the stories of this disrupted time, and in the last part of this chapter I will present a little of how it was revealed through thoughts and beliefs.

### **Landscapes of Consciousness**

Depression is about mood. Moods embrace feelings, and everything that has already been presented in this chapter involves the women's feelings at this worst time. The talk about feelings is deeply embedded in all aspects of the stories, through both metaphorical and descriptive language. As has been demonstrated, the embodied and relationship aspects of depression were dominant in most of the women's stories. Some women also talked explicitly about their thoughts. As has already been noted it is very artificial to divide whole persons and their narratives into kinds of consciousness or awareness implying internal, individual processes. For the purposes of analysis, however, it has proved helpful to consider the ways that the women have talked about



their experience. They have needed to draw upon the language and concepts that are available in society, and these are often in terms of a self made up of mind, body, emotion and spirit. In this section I will present some of their talk about their thoughts.

### **Distorted thoughts?**

As has been seen in the first section of this thesis, much professional attention to the treatment of depression focuses on distorted thought patterns. I therefore chose to look for any evidence of women talking as though they were aware of distorted thinking during their worst times of depression. Because so many of these women were trained as psychologists or counsellors, I would have expected this discourse to be available to them as one of the ways of telling me about their experience. However, the data revealed that few of the women talked specifically about their thought patterns, and none of them placed it in a prominent place in their narratives of this time. Kay, who has some professional training around the mental health area was most specific. She referred to “*you know, the faulty thinking of a depressed person*” and gave the example of focusing each day only on her children, and having no “*real focus on the day*”. Linda talked of how frightening it was that she “*could not think straight*”, and described how anxieties could “*loom ridiculously large*”. Fiona took a year off study because she was “*incapable of creating any kind of thoughts*”, and Karen felt she had a “*huge sense of disorientation*” and a feeling that her memory was “*worse*” than usual and “*less reliable*”.

Kate gave the clearest suggestion of anything approaching the professional symptoms of “*distorted thinking*”. She said :

*The more you sit there thinking the foggier and foggier and darker and darker it gets until eventually you’ve ruined your entire weekend over something that on Monday morning you wake up feeling a lot better, and, and work out what it was, and you just go “Ohhh, forty hours I spent doing that!” What a waste of energy. You know, what a waste of time.*

Naomi, who has professional training in the mental health area reflected on the worst times and concluded that although depression was to some extent a “*mind thing*” that for her it was much more “*a body thing*”. She recognised that in some ways you could “*work on your mind a lot*”, but that depression was “*so implanted in my body*”, which was the “*stuff that’s really hard to get to*”.

## ***Other Mental Health Issues***

All of the women had been given a formal or informal label of depression at some point by a professional. Their own stories have made it very apparent that they experienced many of the recognized symptoms associated with this mental health classification. At this worst time of disruption a number of the women also talked about other possible mental health problems. These included post-traumatic stress, substance abuse, eating disorders, anxiety, obsessive-compulsive disorder and agoraphobia. I have chosen, however, to focus on the total experiences of the women at this very distressing time, and not to attempt to separate one DSM classified disorder from another. I therefore do not intend to discuss these matters separately, and as the reader will see a number of the experiences presented in this chapter could be symptoms of any of the above ‘disorders’. It is more important to this thesis that they were part of the holistic experience of serious distress for these women, and that the women identified ‘depression’ as the disrupter of their lives.

## ***Conclusion***

In this chapter I have presented the ‘chaos’ narratives of eighteen women at the times when their lives were most seriously disrupted by depression. I have demonstrated how these narratives have the characteristics of Frank’s ‘chaos’ narratives: a sense of the incessant present, a feeling of futility, and a lack of any kind of agency. The women had no hope for the future, and experienced a feeling of the bottomless depth of their despair. It was a holistic experience of hopelessness and misery. The despair was embodied, it often excluded relationships with other people, and it was talked of in terms of a loss of life’s meaning.

In the next chapter I will present and analyse those parts of the narratives in which the women explain how they believe they reached this terrible place. In Naomi’s words, the “jolly good reasons” for their lives becoming so seriously disrupted. First, however, I will return to bear witness once more to the suffering of these women at its worst.

At times, as I heard the stories of the worst times I felt I was being bombarded by remembered misery. Their words captured the complexity within the dimension of bleakness and terror. Since this chapter is about the worst time, it seems appropriate to end it as it began with the heart-rending words of suffering from the eighteen women.

*Despair;  
Futility;  
Bleakness;  
Terror:  
I really did slump;  
I went badly downhill;  
I lost something.  
I really did snap at that point:  
All this chaos going on, it was torture!  
I became increasingly unstable.  
I was just left sort of writhing around...  
I barely existed;  
I would weep at night... I was just so unhappy;  
The part of me inside was in horror;  
The bleakness was always there.  
I would have a picture of myself, naked, in terror, up against a wall and quite little.  
I would curl up on the floor in a foetal position;  
I didn't know what joy was.  
I went into a very bleak place – I just completely turned in and I never spoke or uttered  
one cry, nothing;  
It was like being sort of half dead, really.  
I'd wake up and be tormented.  
The dark, ugly side – it's just terrible.  
I thought I would never recover. I was a robot.*

*There is no light. It's this complete – I mean, the words don't describe a lot. When you  
say despair and stuff like that; they're not enough. It is the most horrific feeling in the  
whole world. When you have got not a ray of hope.*

## Chapter Seven: Jolly Good Reasons

### Naomi's Story about Depression and Choices

People choose to have....

I think that's what the perception is...

Yes.

And its, its like people don't realise  
that there's actually reasons,  
and jolly good ones too.

You know –

That people don't actually choose to have ---

I mean

I guess they choose  
how to deal with it....

Maybe.

You can choose

how to live with it

But not to have it

Or not to have it....

Yeah .....Yeah

Naomi opened her interview with this reflection on depression and choice. She spoke in a thoughtful, contemplative way, seriously considering what she should talk about. What was important in her experience of depression? What might be helpful for other women facing the kind of disruption she had faced over a long period? Naomi was also countering some 'myths' about depression. Her opening words are about a common *perception*, which she then challenges. She wants to make it really clear that women *could not* choose whether or not depression entered their lives. She also wants to acknowledge that women are not completely without agency. They do have some choices, and this is important – they choose how to live their lives beyond the disruption of depression. At this starting point in her interview, however, Naomi wants to challenge the belief that somehow, she and other women have brought this distress upon themselves.

In the previous chapter I bore witness to the women's distress and suffering at the worst times. The women tended to make these stories of disruption the central focus of their narratives of recovery. The worst times were enclosed within a beginning and an ending, although they were seldom told in a tidy, ordered sequence. This chapter concerns the beginning stories that the women told about the times before their lives were severely disrupted. Being about these 'times before' it is also perhaps, about the "reasons". All the women reflect back on what came before, with many acknowledging "now that I look back" before they offer the present telling of that past time.

The women's distress has been fore-grounded in Chapter Six. In Chapter Seven it will become apparent that the women agreed with Naomi: they did not *choose* to suffer. They all talked about the "jolly good reasons" they came to believe concerning how depression entered into and disrupted their lives.

In their selection of what to tell about the beginnings, the women were setting the scene for a life story in which, at times, depression took centre stage. I asked them to tell the story of their recovery, and they all set this within a life story context. They included in their reflective telling many aspects of their present understandings of themselves; their personal history, their family, their friends, the social context in which they have lived and made sense of their lives, and ideas about who they are, what depression is, what mental health means, and in a wider sense, how they understand the world within which their journey has taken place. For some women, their meaning-making narrative involved a lot of information, speculation and conscious re-consideration of their life before the worst disruption by depression. For others, this early part of their journey occupied only a small part of the narrative.

Sometimes the way that the women talked about happenings in their life assigned a meaning which at first seemed to me to be incongruous. Something which I could interpret as traumatic was talked about as though it were of little importance; in contrast, other events which might seem to me to be relatively minor took on a high level of significance. These unique ways of talking about a life journey are important in the analysis because they enable the researcher to understand something of how each woman has constructed and reconstructed a meaningful life story, and thus a meaningful life.

The shape and content of each narrative reflects not only each woman's lived experience, but also the communal stories which were available to use as a framework for telling, languaging and shaping her own life story. These meta-narratives make

some positions readily available, and other positions either very inaccessible, or entirely unavailable. To some extent the telling of the introductory stage of each journey indicates which cultural stories the woman was able to call on at the time of the interview to make sense of her early years.

In many of the ‘beginning’ stories the women were doing as Naomi did, and countering or supporting widely believed theories about the origins of depression. These theories are amongst the most accessible cultural stories, and I will comment on this aspect of the stories. Draucker and Hessmiller (2002) suggested that women’s narratives of rape may “serve to provide a plausible account of the rape events” (p.221). This chapter presents the parts of the women’s narratives which give a “plausible account”, or as Naomi said, “jolly good reasons” why they believe depression disrupted their lives. There is more variety in these stories about reasons than there was in the ‘disrupted lives’ stories. The reasons presented reflect the differences in individual lives but they also reflect the context within which they are being told and this is in part the context of the ‘psy’ society and of the dominance of the medical discourse of mental health. A significant narrative feature of these ‘explanatory’ stories is that they frequently involve a dislocation in the storied lives the women might have expected to experience. They “violate canonicity” (Bruner, 1990, p.12).

This chapter contains four major parts. The organisational structure reflects one of the most important features of these parts of the narratives as I read them. The total narratives of the women’s journeys into, through and beyond depression show patterns which will be discussed in the final section of the thesis. The shape of the stories of the reasons for depression are a significant part of the overall patterns which emerged. Thus I am using these patterns as a way of presenting the “jolly good reasons”. The first part of the chapter is introduced with Chloe’s words “I just only remember it being there”. It includes the women’s stories where they tell of beginnings which stretch back to birth or earlier. The second part gathers together the ‘beginnings’ which suggest that the origins of depression lay, at least in part, in childhood experiences. The third part presents the beginning stories which focus on the women’s adult lives. The final part involves issues talked about as being lifelong.

### ***I Just Only Remember it Being There***

For thirteen women, depression has in some ways been a constant presence, talked of as though it were ‘always/already’ a part of their lives. At times, this constant presence was spoken of as being a part of their ‘self’, at other times they spoke of it as having a biological or genetic origin and in some way ‘running’ in the family. In an even broader contextual understanding, depression was spoken of as an inevitable part of some women’s cultural heritage.

### ***I have always been a depressive***

Chloe and Ruth acknowledged that depression had been part of their lives from birth, speaking of it as part of their identity. Chloe started her story by saying “*I think probably as a child---I just only remember it being there--*”. Even before the worst time she remembered only one year without “bleak depression”. Ruth said:

*I think I can go right back to my childhood---This little girl who had so much energy and her parents realizing that energy needed to be harnessed in constructive ways because when I wasn’t energetic and doing things I would feel quite sad about things.*

She talked of depression as an “*old friend*”, a companion throughout her life. Elizabeth also experienced constancy and when she had noticed depression re-entering her life she recalled thinking “*oh, oh, so there it is again*”. Anne called depression a “*life phenomenon*”, and in early adulthood Marge realised she could recall depression as a “*mild, mild grey along the way*” over many years. Then she spoke of her realisation that it was a constant – that “*Oh my God, I have to do this for the rest of my life*”.

### ***Bio-chemical, genetic or familial origins***

Some women talked of the constancy of depression in a more biological way, in terms of a personal or family pre-disposition, or of genetic factors. Christine, for example, believed her depression was largely to do with “*neuro-transmitters and stuff in the brain*”, but alluded also to “*personality*”, speaking of herself as a “*type*” who “*goes looking for all the reasons why I am to blame*”. Kay talked of her possible “*pre-disposition to depression, in response to significant stress factors*”, believing it could be part of her “*make-up*”. Elizabeth believed there “*may be a genetic factor*” talking of the “*history of mental illness in my family*”. Her father had a history of chronic depressive illness and committed suicide when Elizabeth was a child, her mother

*“chewed Valium all day and Mogadon all night”* and her son has mental health problems.

Without being as specific as Elizabeth, other women also referred to a family history of mental health problems. Anne said *“my mother was critically depressed at the outset and all the way through. That is the underlying statement to the story, really.”* Isobel’s brother and mother both attempted suicide. Her sister suffered from depression and spent time in a psychiatric hospital, and she referred to her family as *“really crazy”*. One of Ruth’s children has had a diagnosis of *“manic-depression”*. Hine tells of both her parents spending time in psychiatric hospitals. She *“guessed”* that she would be *“more like my Mum, who was always depressed”*. Hine’s mother was hospitalised with a breakdown when Hine was a toddler, and her father spent some months in a psychiatric hospital, with a diagnosis of kleptomania.

Some stories drew on the medical discourse involving hormones. Chloe talked of a time when *“pre-menstrual tension was pretty rife in me”*, and Ruth commented that *“there are times when I know that my hormones, the chemical brain of my body.... could be my enemy again.”* She had earlier talked of *“post-natal depression”* and of *“the pre-menstrual thing”* becoming *“quite big”*.

### **‘Cultural’ Invitations to Depression**

In the study design I recognised the culture of gender by including only women, assuming their narratives would differ from those of men. Many of the women considered ‘being a woman’ specifically as one of their *“jolly good reasons”*. Ruth made this connection:

*I actually think depression is part of being human .... but the stress levels in society, stress, stress, stress, burn out and being female, working full time and then running a home.*

She saw her mother and sisters suppressing anger and becoming sick, and when she experienced similar emotions she decided *“Stuff you, that’s not going to happen to me”*, and talked of *“the rage and anger, the role-typing of women”*. She reflected that *“depression and women have an interesting partnership”*. Karen referred to the negative impact of role expectations, reflecting on a time just after her marriage:

*I wasn’t working because I thought I’d need to learn how to look after a house and all that stuff. Quite traditional in my thinking. You know the traditional woman’s role. I was right into it. And I wanted to make a go of it. And I hated it right from the word go. I just absolutely hated it. I didn’t really fit it at all.*



Charlotte married in the sixties, before the second wave of feminism, and believed she was “*hampered*” from “*doing things for myself*”. Some women compared their lives with their brothers’ lives:

*...that denial of intellect, I can see now that it was my own upbringing in the sixties and seventies. It was my brother that went to university. “What are you going to do Kay?” You need to have something you can fall back on.*

Fiona grew up in a rural area where her father and two brothers lived a life which required Fiona and her mother to position themselves as “*total feminine support*”. This support included cooking, washing rugby clothes, and organising so the men could go motorbike racing.

*I mean we just worked flat out. I look back now, and I think - how did that happen? It was just like our energy was completely taken over, by my father and my two brothers being such active, achieving --- they were like, physically large chaps. .... Very nice guys, but quite forceful. And I look back now and I think, yes, Mum and I really did just run after them.*

Fiona internalised these gendered expectations, recalling how, for much of her adult life, “*I thought of myself as just a cute little lady, a cute little girl thing that didn’t go and take the world on.*”

Other gendered expectations related to body image, and to child-bearing. Naomi considered “*the body image stuff is even worse than it used to be, I think*”. Linda was expected to become pregnant as soon as she married. She had sexual difficulties which made this impossible, but felt she could not “*talk about these issues*” and that she had to put up with the “*assumptions*” of “*friends, colleagues and family members*” and their “*questions on a weekly basis*”.

Some women made links between their disrupted lives and the marginalisation of disability, ethnicity or sexuality. The physically disabling condition that Karen lived with from birth is an ever present part of her narrative. Hine talks of her identity as Maori and lesbian increasing her vulnerability to depression.

Naomi spoke explicitly of the connection between her cultural identity and the depression which was an ‘always/already’ presence in her life. She linked depression with the “*script*” she had as a Jewish woman that “*I am in this world to suffer. I am in this world to repent*”. She added, “*this is all holocaust*” although some is also “*family*”. The beginnings of her depression existed well before her birth:

*Life is not to be enjoyed, life is to be endured. This is the message that I've had from day one. That – and all my history, my ancestry.*

Naomi names her enduring experience of a life without joy “*cultural depression*”.

### ***Beginnings in Childhood***

All the women talked of their childhood, but with varying emphasis, and seemingly different motives. When women talked about distressing childhood experiences they often included a lot of detail, and clearly connected these experiences with depression. Where the childhood recollections were positive they did not occupy as large a part of the narrative.

The six women who talked of childhood abuse or violence presented their childhood experience as very significant in their journey. Three women talked about emotional abuse or neglect, and another five talked of traumatic losses they had encountered before they were adults. Thus fourteen of the eighteen women talked about some kind of childhood trauma.

### **Childhood Abuse and Violence**

If these women had been interviewed as children, many would not have labelled their experiences as abusive or violence, and some acknowledged that they could only name the frightening aspects of their childhood from the distance of adulthood. Anne, for example, talked about her father:

*His discipline was really heavy handed. So he would lash out really in a very, quite a brutal way .... If somebody had been watching from the outside they would have called it physical abuse in terms of heftiness, unnecessarily hefty. And the regime of rosters and jobs and....This was just reality – yeah. Which is why, see I... I'd never thought in terms of naming it until much later....*

Chloe's family situation was similar. She spoke of her father as a “*very violent, and a very angry, unhappy man*”, her mother as someone who had “*incredible rages*” and her childhood as a “*state of terror*”. Isobel's childhood was “*horrific*” with “*an alcoholic father who used to beat me up on a regular basis ...*” and he “*hated females*”. Karen talked of her alcoholic father as often “*ranting and raving and boozing*”. Karen did not recall that he ever hit her or her mother, but he was “*verbally really aggressive, nasty*”. She talked about “*so many traumas she had to forget*”. In addition to her father's anger, she experienced abuse during her childhood and youth from medical professionals. She often needed to be examined in hospital where:

*There was a huge amount of medical abuse went on. Unaware. I don't think it was intentional, but because it was a teaching hospital there was a lot of inappropriate ... a lot of genital exposure and sequences of medical students standing looking at my genitals. There was a lot of that depersonalization that was absolutely frightful. Oh, that was absolutely dreadful. And just such a sense of powerlessness. I dreaded it, hated it, I really cringed. That's another factor feeding into why the intensity of the depression.*

Hine, like Karen, told of more than one kind of abuse and trauma in her life. She talked of depression coming partly in reaction to “lots of various and horrible things” that had happened in her life, including a sexual assault in her childhood. She is one of the five women who commented on emotional neglect or lack of nurturing.

*I'd never, I mean, maybe I did when I was really little, I can't remember that, but I'd never had in my life anybody that fussed or nurtured me. I mean I got fed and I got sheltered and clothed, but I never had any one-on-one kind of nurturing attention.*

Anne, Chloe, Elizabeth, and Naomi all talked about the emotional unavailability of their parents. Chloe spoke of her mother as not only violent but also “very self-absorbed”. As a child, Naomi needed to put on a “happy, pretty face” and be part of a “lovely family.” There was no “incorporation of feelings, or being silly, or being childish or playing. Nothing like that. We had to be dolls.” All the stories are complex, and some hold contradiction. Karen, for example, made it clear that her family offered her positive as well as negative experiences.

Trauma, neglect and abuse in childhood often result in a loss of innocence, joy and spontaneity. These were not the only factors resulting in loss and grief.

## **Grief and Loss**

Five women told of significant losses in childhood. Jane experienced many:

*I knew that when I was under five I had nine months in a children's home, while my mother had TB. But .... actually she had two years in hospital, previous to that..... I never knew about it. I was never told. And there are gaps. There are no photos of me or children with their parents in those two years. There's photos of us. And I look very sad. And I look different. I don't have my little white bow in my hair, or beautiful hair style. I've got very curly hair. I've got very messy curly hair. And my clothes look a bit odd. Mum dressed me very nicely, you know. So there was loss there. Obviously. And then my mother died when I was eleven. And, and then my grandmother died and she probably was the person who looked after me for those two years.*

Karen had to live with the loss of her physical abilities, because her condition became progressively more disabling. She said *“my whole growing up was just so distorted by the physical realities of my life”*. When Linda was a child she lost her *“closest adult friend”* through a car accident and realised that *“if she could go like that, so could my mother, so could my father, so could any member of my family”*. In her late teens Hine’s boyfriend was killed in a traffic accident, and she was left *“bereaved and abandoned”*.

Fiona initially talked of a childhood without trauma, but when she talked about hip surgery she remembered something significant from childhood. Her problems with her hip dated back to an accident when she was a teenager. She was hit by a car, suffered multiple fractures to her leg, and considered herself *“lucky to be alive”*.

Two of the women incorporated parental separation into their narratives. Hine talked of being *“absolutely grief stricken”* when she was a toddler and her Dad left home, but did not emphasise this part of her journey. Kate, in contrast, told of her parents’ separation as very significant:

*Now I look back on it I realise that probably... the depression started when my parents split up when I was ten. And ... it was all very amicable; they didn’t have a particularly nasty split up. But I do remember feeling very responsible for my father, who --- my mother left him. And took my brother and I away, and then I went back to my Dad, because we were only a mile down the road with my grandparents. And I just, I can remember quite vividly feeling just awful at the fact that he was living in the family home without us, and that he was alone. So, I went back to look after him. Which of course I didn’t do, because I was only ten.*

Kate emphasises the importance of this separation in her journey when she mentions it again later in her narrative. *“I kind of traced a lot back to my parents. And the divorce. And things.”*

Katy’s parents did not separate, but she was separated from them. They worked ‘overseas’, so she was sent to boarding school in the UK when she was ten. Within the boarding school environment she was an ‘outsider’ and excluded from the friendship and company of the other girls. She reflected back on all the things she learned from that experience and overall considered it a positive experience and one that increased her resilience. However, initially, she recalls being grief-stricken:

*when I was 10, I was sent to boarding school, to a very exclusive boarding school, girls’ school. And bear in mind that I hadn’t been away from home, I’m an only child ..... I’m only ten, I’ve never been*

*away from home, I miss my family. My mother and father were the only family I'd had. And they're in xxxx ..... I'm in England. I couldn't even run away. You know, if I'd wanted to. And I remember lying in bed one night, and with the blankets over my head, and handkerchief stuffed in my mouth, so I wouldn't make a noise, and crying and crying and crying. Wondering why people didn't like me. .... nobody wanted to know me. Nobody wanted to play with me.*

Anne was also separated from her parents, but not till she was sixteen, when her father took a job elsewhere, and she and an older sister did not want to move. Anne recalled that the family “*moved around a lot, which is another reason I see as having tipped the balance for all of us at critical times*”. A story about the guinea-pigs her grandmother had given her, explains the impact on Anne of the family moves.

*I took them. It didn't matter where we moved to and it didn't matter what peer situations got disrupted as long as I had my guinea pigs .... Mum and Dad had no concept of what they were disrupting each time they moved us out of a peer group and/or a school ....*

Anne's parents never visited her during her last two years of secondary schooling. The separation highlighted her emotionally barren life with her family. Anne recalled that she and her sister “*found ourselves in these homes of people we didn't know and it was actually no different*”.

Anne has started and ended this section. She is one of many women who talked about a range of difficult aspects of their childhood.

### ***Beginning Stories Centred in Adult Life***

Some stories in this section began in childhood but moved seamlessly into adult life, including many of the stories of ‘otherness’ and of poor self-esteem. Other stories are contained within the women's adult lives, including stories of trauma, grief and loss, stories of difficulties related to child-birth and mothering, stories of the break-down of intimate relationships and stories of work-related stress. There are also stories of isolation and lack of support; experiences which are often linked to geographical, or interpersonal dislocations in the narrator's life.

### ***Abuse and Violence***

As with the stories of childhood abuse and violence, the traumatic and violent experiences of adult life often took place in the context of the women's closest, most intimate relationships.

Three women talked about intimate partner violence. Naomi said that for a long time she looked for “ways to fight for my life” and at one point found herself in “a violent horrific marriage”, from which she fled to the opposite side of the world.

*That was fleeing, I mean, boy. I look back at that and I think, --- because I mean by this time, you know, there was this violence going on and --- and I, I'd taken out an injunction order .... and oh my God he was following me, and--- I was sick. I was vomiting up. You know, it was horrible, it was horrible. It was absolutely .... it was a nightmare, it was a horror movie.*

Ruth had a peaceful and supportive childhood, but early in adulthood she, like Naomi, entered into a “very violent marriage”. She said “I was beaten, I was raped .... that knocked me around.” Chloe talked of a relationship in her twenties as “it wasn’t good. It was vicious.” She went on to become involved in a number of long-term violent, abusive relationships with men. When talking about one of these she said:

*....so he was drinking an awful lot. And so he and I became hooked up in this incredibly awful, (laughs) oh it was horrible. God. Even when I think about it now I think, hell, it was just out of control.*

These three women were the only ones to talk about intimate partner violence but others emphasised traumatic events in their adult lives, many involving grief and loss.

### **Traumatic Experiences including Grief and Loss**

The emphasis placed on traumatic events varies, and is not clearly related to the apparent seriousness of the trauma, but to its meaning for the woman at the time of telling her story. Thus Ruth tells of a traumatic experience just before her first really bad episode of depression. When she had talked of her violent marriage she was brief, and said little more than the words I quoted at the end of the previous section. The episode I am about to recount was, in contrast, given a lot of time in her narrative. She recounted it in fine detail, and connected it directly to the onset of depression. Ruth was “nearly killed” when she became stuck in the automatic door of a train as it began to move away from the platform. She was only saved and thrown onto the platform at the last second before she would have struck a tunnel entrance. In more recent times she has experienced major conflict over child custody cases going to court, and also her mother died, and her husband suffered a major heart attack. She talked about including all these traumas in her narrative because she saw them as triggers for her major depressive episodes.

In contrast to the central positioning of these traumas in Ruth's story, Chloe mentions almost in passing that she had a car accident and knocked herself out for a while, but does not elaborate on this at all. It happened in the midst of her series of violent relationships with men, and they were more pivotal in her story. Later in her life, after she had entered into a good relationship and when she was pregnant, she experienced a trauma which had a more metaphysical impact, and which she connected to depression. A very good friend was killed in a car accident, leaving two young children. Chloe described this death as "*bewildering*", and explained that she had been beginning to develop a glimmer of spirituality, but that this death "*did not make sense at all*". She recalled that she "*lost a fair bit of hope from that occasion.*"

Hannah's mother's death closely preceded her first serious episode of depression, but was not told as a significant trigger, and Marge linked compounding losses with depression re-entering her life, but as a sub-plot to the major employment-related triggers. Marge's losses had included her father's death which many professional therapists might have expected to be more significant than the death of Fiona's father-in-law. Fiona, however, told how this death was a major traumatic episode in her adult life. She had "*hardly been to a funeral for years*", not since her own father had died many years before. There had been no tragedies, no accidents. So for her it was "*like being at my father's funeral*".

Fiona's talked of her marriage break-up as the most important reason for her depression. However, as well as the death of her father-in-law, she tells of the deterioration in her physical health as very significant. In her talk about that loss she reflected on its meaning, offering some idea of how events acquire a unique meaning in narratives and in lives. Fiona found she needed a hip replacement.

*That was another thing that to me was a total shock. Because I knew I had a bad hip. But you see your hip is such an intimate part of you. It's where your femininity or masculinity is. You think of everything you do with your hip. That's where you carry your baby. That's where your procreation is. It's where you sit and stand and lie. It's where you love from. Your hip, your pelvic area is everything. Central to everything. It's so profound. And here's this guy telling me I'm going to lose part of it.*

The stories told by Christine and Kay include events with a traumatic impact that might be more widely expected and understood. Christine's second serious episode of depression followed a pedestrian running out in front of her car and being killed. Kay experienced the short and long term effects of a serious accident involving her husband.

*He had a head on smash on the open road that he contributed to significantly. And he was very, very badly injured – As an orthopaedic closed head injury patient he was just absolutely foul. His foul language, self absorption, self-centredness and not being able to delay gratification for things.*

Kay links the accident to her depression saying “*that second episode of depression was really, I guess, post stress stuff after that big accident*”.

When Linda was a young adult her sister came close to death through anorexia, and around the same time her brother received serious permanent injuries in a road accident. Linda experienced anxiety as well as depression, and links the traumas with the anxiety. Her ‘depression’ story, however, focuses on a very different aspect of her life which will be presented later in this chapter.

### **Interpersonal trauma**

Two of the women, Chloe and Hannah had particular interpersonal experiences which, like Fiona’s hip operation, have a somewhat surprising significance in their stories. Surprising, perhaps, because they do not conform to any of the dominant theories about the ‘causes’ of depression.

Chloe’s experience related to the women’s movement, and she found it far more “*devastating*” than her previously mentioned car accident.

*I ... was always sort of a bit of a feminist, and at that time ... women’s action groups were going on.... on one particular night there were all these, we got wind of all these fundamentalists, sabotaging these meetings, and that was dreadful. .... Oh, my God, I was devastated ... I hadn’t experienced women not being supportive of each other. They just hated what they saw as us. The feminists in the .... (sighs). Yeah, I was just blown away by that. So we became the enemy. So that happened. Full on, angry women. Just dreadful. Scary.*

This incident challenged Chloe’s sense of belonging amongst feminists, and her feeling that women’s groups were a safe environment for her.

Hannah’s “*crisis*” challenged her sense of her extended family as a safe place. Her young daughter was “*seduced*” into a relationship with her older lesbian step-sister. This happened when her daughter was staying with her father and step-mother and continued for months before Hannah found out. Hannah connected this crisis and her associated feelings of guilt and responsibility, directly with an episode of serious depression:



*So --- a lot of guilt --- lot of guilt. I had guilt because of course, I thought, well if I'd never broken up with her father, then--- we would never have experienced this--- so, we never would have been walked this far... You know I was very, very distressed over that because that broke the family unit up as such .... But I never went back on medication that time --*

## **Break up of Intimate Relationships**

Nine women include the break up of their marriage in the narratives. For five it is central, but for the others it does not hold the same significance. Six of the women, presented the ending of an intimate relationship, at least in part, as a positive move towards a safer, less stressful or more satisfying life, and these stories will be included in later chapters.

Fiona is one who centred her narrative on the breakdown of a marriage. She set the scene for her narrative:

*If I was going to start anywhere I would like to start in 197- , I had finished my training ..... and I had met the most wonderful man, and we were right for each other, and we got engaged and we got married. And we waited. Well it was at that time that we wanted to get a house, and put a deposit on a house. And we also wanted to travel overseas before we had children. So we pooled together, and we thought ...well. And we were very happy, and I was happy. I was a happy child, I grew up in a good family. ... a loving, happy family.*

She talked at length and in detail about the perfection of her marriage, including the births and raising of the children, creation of a beautiful family home, family friends, overseas travel and involvement in extended families. After building this picture of the traditionally perfect family she introduced into the story the first signs of discontent. Her husband “*started to withdraw emotionally ... He never opened up to me .... He was in the process of closing down.*” This closing down ended with his leaving her and the children after twenty-five years of marriage, and this is where the depression entered into and created a major disruption in Fiona’s life. She introduced this into her narrative by recalling his announcement: “*I think the marriage is over, and I want to go*”. Fiona said “*I was so unhappy. It was so awful for me to contemplate.*” Later in her narrative Fiona said “*I think when my marriage ended it got .... it triggered abandonment, death, economic security.... I had a certain social position.... Divorced woman. Pooof. The divorced man might have some value, but the divorced woman tends not to.*”

Isobel's story also centred on her husband leaving her. She said that the realisation that her husband was unhappy in the marriage was "*where it started kind of logically*". Like Fiona she recalled how they had always been seen as "*the ideal couple*". Then he had an affair and his leaving "*broke up our family*".

Jane introduced her story with the statement "... *it started when my husband ... told me that he was leaving*". Like Isobel she had believed her marriage was "*for keeps*", and she knew that "*divorce was not part of my world view*". Jane had experienced some major losses in her life, however, the end of her marriage was for her the worst.

*.... a flat mate died and then my brother was killed in an avalanche, so there was a lot of loss. And so then, my ex-husband leaves me- that was the ultimate loss. Yeah. And I guess I, I think that's why I've done it so hard, so hard, and crashed so badly.*

Fiona, Isobel and Jane tell of 'ideal' marriages, which were ended by their husbands. The endings were unexpected and shattered the life story around which the women were creating their lives. This story of falling in love and living happily ever after is readily available in our society, through fairy tales, movies and many other dominant sources of acceptable and preferred life stories for women.

Other women 'believed' in marriage, but made their own choices to leave when their marriage did not work. Ruth, for example, stayed for thirteen years in a marriage that was "*very unhappy*", and she knew that her "*needs weren't being met*". She stayed because "*when you get married it's a commitment, do your duty*". Finally she decided to leave, realising the marriage was bad for her. Naomi and Kay also left very unsatisfactory marriages. For these three women it was the marriage that had a negative impact on their lives, not the eventual break-up. The decisions were not uncomplicated. Kay knew she was married but totally without "*an effective, mutual, supportive relationship*", however, she was "*afraid of taking the very precipitative plunge*" of leaving. The decision was complicated by her husband's head injury, and her loyalty to him. Naomi left because the violence was horrific, but still she felt "*abandoned*".

Chloe also left relationships which were "*unhealthy*" and "*unsatisfactory*", but still felt "*devastated*" and "*rejected*" and found she often "*slumped*" after another bad relationship ended. Hannah's concern, when she left a very unsatisfactory marriage, was the impact of the separation on her relationship with her children. She knew that in her marriage "*the communication was zilch. It would not have worked.*" Nevertheless

she was the one “*that moved out*” and after that decision she went “*down hill really badly*”. She went into a “*major, major depression*”. Anne left a marriage where communication was very poor. She was then on her own with two young children, and although they are now young adults, she has decided not to risk another intimate relationship.

### **Difficulties in relationships, or absence of relationship**

In addition to the issues around committed, intimate relationships, many women mention problematic relationships with peers and experiences of poor interpersonal communication. Issues of isolation and lack of support are also presented under this heading.

#### ***Poor Interpersonal Communication***

Poor interpersonal communication is a common feature in the narratives, but it is not simply about poor communication skills. Some women acknowledged their need to communicate better, but others believed that their partners were unable to communicate meaningfully with them. There was also a recognition of mutual breakdown in communication, or of difficulty finding people to communicate with or contexts within which meaningful communication could take place.

Katy tells a vivid story of unsatisfactory communication and its significance. She does not want to waste her time being sociable and nice. “*To me that serves no useful purpose whatsoever – that’s trivial – for people who’ve got nothing else in their lives.*” However, she had to be ‘nice’ over an extended period of time before her daughter’s wedding. She said “*I’m a strong stubborn woman. And having to be this nice woman for several hours. Not only at the wedding itself, but leading up to it ... I found it a real strain.*” She linked this to her second major episode of depression, saying: “*I found it a real strain and I remember saying to somebody during the wedding, when this is over I’m going to have a breakdown ... do you know, that’s exactly what happened.*” The wedding was not an isolated situation for Katy. In some of her close relationships she found that a person would “*listen to me*” but that their “*eyes’ll glaze over*”. So whenever possible she sought instead to “*talk to somebody who does understand*”, knowing how important this was to her well-being.

Naomi talked about a range of relationship difficulties in her life. However, where Katy highlighted weaknesses in others, Naomi focussed on her own failings. She said “*I’ve always felt very unsuccessful as a mother, or as a friend. I’ve always felt...*

*well, I don't quite get that right either."* Marge also saw the need to improve her own communication. She talked of her shyness as she grew up, and the work she felt she needed to do to improve on the "social stuff".

Chloe talked a lot about relationships. As the only girl in her family, she was sent to boarding school to experience female company, but found it "bewildering" with "all these girls". In adult life her female friendships were "alright", but "it was in the male-female that I was a mess". She reflected on her early adulthood and observed "I didn't know how to be in a relationship". Her first two serious relationships were with "good" men, to whom she was "unkind, mean and vicious". She linked these 'troubled' relationships with her journey towards depression "I think life started to slip for me then ..... the whole thing around relationships was feeling .. yeah, I need to feel in control, I think". She then got involved with men who were not 'good', and who often drank heavily "just like Dad".

Linda's early relationships were characterised by poor communication. She chose men "who were aloof. Extremely intelligent, and totally not connected with their feelings. So – it was just a dead end."

### ***Geographic Dislocation***

One of the first things I noticed about the narratives was the number of women who talked about geographic moves. As I became more immersed in the stories I realised that these moves were often included because they resulted in isolation and lack of support.

For Charlotte leaving home was the start of her journey towards a life disrupted by depression. First she went to university then her isolation from family and familiarity was compounded when she migrated to New Zealand. Her words capture a feeling present in many stories:

*It probably started when I left home. 'Cause I was brought up in a very, very tiny place. You know eight by five, and nine by six, sort of thing. This was a kind of country-like community and a small community within that community .....where we lived was very, very small, and sort of miles from town ... and I went to, I went to university, and I did it almost deliberately, because I wanted to see what it was like then, away from the sea ... it was a, a cultural thing I think. And thinking about it now I started to have all sorts of physical problems and I was desperately homesick, and it was a very difficult thing to settle. It wasn't a happy three years.*

Katy was separated from her family at an even younger age, when she went to boarding school. This story was told earlier, but the childhood experience was repeated when she married and moved to New Zealand. She found herself with “*no friends, no family*”. Katy’s social isolation in New Zealand became a significant factor in her first experience of depression.

Kate emigrated from Europe to New Zealand with her very supportive partner but still had “*no support network, no friends*”. She connected this dislocation to the onset of agoraphobia, although at the time she had trivialised the impact of her geographical move. “*Oh, well I’m homesick. Oh, well I don’t know people so I’m lonely.*” Hannah came to New Zealand when she was only 17, and found she had no one she “*could really rely on*”. She considered “*that’s when it [depression] must have all really started*” because she “*felt very lonely, alone, totally alone*”. In telling this story Hannah illustrates the nature of all these stories, as present tellings of past experiences. She reflects on the different meaning the move had at the time:

*So we came out from the UK. That wasn’t an easy time, but it was an adventure. So, if I look back on it, I see it like that. But, you don’t realise when you immigrate, cutting ties with the rest of the family, you don’t realise that the support system isn’t there. You’re not even thinking like that.*

Christine helps us to understand another difficult aspect of geographical dislocation. Her husband needed to move to Australia for work when their children were young. Christine found the move to an unfamiliar place encouraged the anxiety and worry that she saw as an aspect of depression.

*Anxiety. It emerged again. Weird stuff. I feel embarrassed when I say it.... my thing, germs, blood, faeces, condoms, just (this is so embarrassing saying this) but .... and you know, a big city like X .... we lived by the beach, and everywhere there’s .... kind of things .... and I had these kids .... and it turned into “Don’t touch anything. Don’t touch the door knobs.”*

Unfamiliar places were also difficult for Elizabeth who moved just after her marriage and became “*fearful of people*” feeling she was “*in a sense quite isolated .... and insular*”. “*Getting out and meeting people*” became a “*big thing*”. Marge moved from the country of her birth to New Zealand when she was in her twenties and commented that she had “*sort of lost my support system*”.

### ***Loneliness, Isolation and Lack of Support***

Geographical moves and communication failures are not the only reasons for loneliness, isolation and lack of support. Kay lost the use of her car when her first child was only months old. The car was crashed by a family member. Kay said that she found this lack of mobility and the resulting isolation “*really extraordinarily difficult*” and felt nobody understood the significance of this loss. Just before Hine was hospitalised following a diagnosis of depression she had been living on her own with three small children. She said “*I’d been isolated with children at home, no money, no friends, no transport ....*” .

Social isolation was also important in parts of Linda’s story. When she finished studying her workplace had very few other staff. She got “*a really low depression*” that she linked with “*loneliness*” really “*hitting in*”. Later, she went through another low stage, and said “*my aloneness was adding to that. The fact I didn’t have a permanent male partner.*” Again there is a link with society’s stories of the successful woman, who is one who meets a suitable male partner and they live happily ever after. Linda had a sense of failing that preferred life story.

After Fiona’s marriage ended, social isolation contributed to depression moving into her life. She realised that “*I don’t have any sisters. I don’t have any friends that are long term friends.*” Karen experienced a sense of isolation when she was invited to take a special course at university. She was flattered to be in it, but found that she was one of only a few women amongst a group of “*pretty fierce men*”. She found that year an “*unmitigated disaster*” and it resulted in her “*blowing up again*” with depression.

Naomi talked of her isolation in a more profound way. Her sense of aloneness lasted from her adolescence into her adult life:

*Nobody picked up.... nobody picked up. No teachers, no aunts, uncles, parents. I mean there was no-one. No-one. That’s one thing, I think, that it’s the biggest --- like when I, .... [Talk to other people] , “Was there anyone in your life?” And they’d sort of go, “Oh a grandmother”. You know someone who there was a little bit of connection with. And I think that’s what, really, really tipped it off for me. That there was absolutely no-one in my life. Not my brothers, you know. No-one. There was I, I was so isolated in my experience for so many years. That’s, that’s what made it worse. I mean I think that could make all the difference. Just one person.*

Anne commonly felt alone, and her worst times with depression happened “*when there was an emotional crisis of separation, which is what it always was that*

triggered it". Later she reflected on her negative experiences with relationships and her fading hope:

*I think when I was young every new relationship, not that there were many but, it always had this sense that this time it's going to be okay. This time my needs will be met. This time I won't be lonely. This time.*

Chloe talked of "feeling unhappy and very lonely.... very lonely" and Ruth found that for her loneliness and lowness in mood were often closely intertwined.

*....when I wasn't doing something creative, or physical, that's when I just about, was feeling quite lonely. And ummm, quite lonely, alone, but not so alone, and mainly that I'd be crying or depressed...*

Only three of the participants in this study, Christine, Isobel and Jane, do not specifically include loneliness, isolation or lack of support in their stories.

### **The Complex Issues Associated with Becoming a Mother**

Becoming a mother was an isolating experience for many of the women, including those who moved from paid work to full time parenting. The historical and geographical contexts within which the birth took place were important. Charlotte, Katy and Hannah all had children before the 1970s, and all had moved to New Zealand from Britain as young adults before they had children.

Charlotte's symptoms of depression became apparent after she stopped work and had a baby. She attributed these symptoms to her major change of life style and particularly to the lack of support: "*when I stopped to have this baby I had no support*". She had moved from a fulfilling professional job, where she had the company of other intelligent women, into a newly acquired suburban house without any transport. She connected this dislocation with her earlier geographical move:

*the culture shock from moving. From place to place. The not having that support group. And coming from that very close knit ... community --- which was a sort of very extended family.*

Katy also connected depression and childbirth. She explained that she had had two distinct experiences of depression, many years apart, and the first one could "*easily be put down to post natal depression*". She mentioned many isolating factors similar to those experienced by Charlotte. Katy also talked about her determination to "*be a good mother*" and how this was challenged when her son was unable to breast feed but experienced a bottle "*like it was ambrosia*". As with the stories of meeting a partner, falling in love and living happily ever after, there is a readily available story of the joys

of being a successful mother. This story could be expected to be lived out by any 'normal' woman.

Hannah, too, felt isolated with young children. However, for her, the particular lack was that of family support, and although she had friends, neighbours and a husband, they did not provide the support she needed. Her mother had said she would follow Hannah and her twin sister out to New Zealand, and then changed her mind.

*I knew there was resentment towards my mother, especially my mother. Because she sort of led the family, and hadn't followed through on what she promised to do. So, and I suppose I felt very adrift, with two children, no real support mechanisms, other than friends, and neighbours, and just trying to cope with the whole lot. And whilst, [my husband] was a very good provider, I mean he brought his wage packet home, there was never any of that he never womanized, he never, he never did anything excessively. He was actually a very good father. But he just didn't communicate. So, the isolation and I think that's the word, the isolation, was, was worse.*

Kay comes from a younger generation, but she too explained that “*the onset of depression*” occurred for her when her first child was two weeks old. She felt out of her depth as a mother, and whilst “*loving this child intensely*” she did not enjoy the process of “*being in constant demand*”. Like Katy and Charlotte, Kay experienced a dramatic change in life style with “*motherhood*”. She had had a high profile job, she shifted house, and she lost contact with friends and with her “*own sense of competence*”. She acknowledged the complexity of this time in women's lives:

*It was a really healthy pregnancy, and a really good obstetrician that looked after me. And, you know very positive aspects, but from the moment I gave birth, it took a long time to find me again, and feelings and thoughts. And in hindsight I think it was a reactive depression to a series of things that happened. That none, I had no time to resolve one of them, let alone eight or ten things that happened. And I think it was certainly in a post natal period of my life, but I don't know if the influence of child birth was the predominant thing. Or whether it was the cumulative effect of all sorts of things that had happened. ---*

Christine's story is the one with child birth and parenting most clearly central to the narrative as a “*jolly good reason*” for depression. She introduced very few other reasons and said her depression “*was triggered by being pregnant with my first child*”. She talked about wanting the baby, having a great man in her life, being home anyway, but then suddenly she became extremely anxious:

*And the signs were there.... if someone had told me them now I could have recognized them. For example, we had an old house .... And I*



*was obsessed with cleaning, and I was hugely pregnant, and I can remember anxietising about the walls and ceiling, and what was up there, and what would come down and land on the baby. And so the only way of getting around that was to actually get up to the ceiling and clean your whole house, and do it, and do it, and do it.*

Christine had hoped to give birth naturally, but couldn't. Then, at two weeks, the baby had a seizure, then the anxiety continued, but took on all the features of depression. As Christine explained, an electrician visiting her house questioned her behaviour:

*....the electrician said to me "Don't you think it's too hot in that room for your, your baby?" And I mean .... it was like a furnace, I had her covered in entire wool things. She was covered. I was so paranoid about cot-death, I had her sleeping next to this heater. Everything that you shouldn't have been doing. Then it got worse, and worse, until I had to sit there most of the day, most of the night, most of the day, with my hand on her. Was she breathing? And then it got to the stage where I wished this baby would die, so then I wouldn't have to worry about her any more. And, I can't do this any more, and I want to give her to somebody else to look after. Man, I just, you know, it got worse, and worse, and worse.*

Christine became obsessed with her baby staying alive, and more and more withdrawn from all other aspects of life. Then when the first baby was fourteen months old she discovered she was pregnant again. This was horrific. She whispered to me:

*I thought "Oh my God, I can't do this again. I cannot do this again." And it was just, wow, it was real rock bottom. I'm going to go out into that lake and kill myself. And that was when I went to, I went to the doctor, and I said, "Get rid of this baby". "I don't want it, I'm not going to go through this. I can't do this."*

## **Mental Health Problems in Addition to Depression**

The labelling of mental health issues is problematic (Chapter Two, pp.29-33). It is common for people to experience a range of distressing feelings which could have many different labels. The women draw on available discourses to language their distress, and many of them have lived not only with depression but also with clusters of symptoms which might earn different labels. Christine, for example, talked about severe anxiety as well as depression. The women talk in mental health language, not only about their own distress, but also that of family members, living and dead. In this section I will firstly present the personal experiences of the women, then the stories they tell about mental health problems and members of their families.

### ***The Women's Experiences of Mental Health Problems***

Anxiety was the most common additional problem for the women. I have just presented Christine's anxiety about her baby. Linda also talked a lot about anxiety, saying she realised as a child that *"my levels of sadness and anxiety were greater than would be considered typical"*. Her mother considered her *"a very anxious, needy child"* and she recalls that she *"had a lot of anxiety about, fear of, the unknown about fear of things potentially happening"*. Linda recalled that she did not like *"doing things on my own"*:

*I didn't like thinking of myself as a separate body person, that would kind of freak me out. If I was in a situation where a lot depended on me - then I, then I could often feel overwhelmed by anxiety.*

Marge also experienced what she described as *"incredible anxiety"*, particularly in work situations. She considered this anxiety to be linked very closely to her experiences of depression.

*I think I really kind of got to the bottom of what it was that was going on. You know, the performance anxiety. My feelings of not being good enough. I grew up in an extremely religious household. Well community, I went to a religious elementary school, high school, college. So I got a lot of messages of "you're never going to be good enough. You are never good enough." Which is why I've had trouble at work, because you know I can never, I can never perform well enough.... I always have this fear of criticism. That somebody's going to criticize my work, or I'm not going to be good enough.*

Naomi was afraid that *"someone will expect something from me, and I won't, and then I get anxiety that I won't live up to it"*. She recognised that she can *"go into a place of failure before I've started"*. Kate's anxiety showed itself as agoraphobia (an abnormal fear of open spaces or public places). She realised how bad this was when a dog turned up on the doorstep, she decided to keep it, and it needed to be walked:

*she forced me to leave the unit. And when I'd got her I suddenly realized that I didn't, that I didn't label it as agoraphobia --- not at all --- (laughs) ---- but I did, it did suddenly cross my mind that I didn't actually leave the unit from one day to another.*

Many women talked about addictions, or obsessions with food, alcohol or drugs. Chloe struggled with food and alcohol:

*I was becoming aware that I had problems. That I was drinking too much. And I was taking buckets of laxatives....I knew something wasn't right. I used to buy packets and packets of chocolate biscuits and just eat them and then vomit it out again. Just for, that was my comfort. Just used to yearn for it. And I knew that wasn't very marvellous.*

Chloe's problems with alcohol finally resulted in her being caught for drink driving and losing her licence for six months. Hine had problems with drug and alcohol abuse during her teens, and considered these were ways of coping with her experiences of sexual abuse through "*chemical dissociation*". Kate talked about how dope smoking became a problem for her. She said she "*took far too many drugs*" and

*You would go and walk the dog, but you'd have to have a joint while you were walking the dog. And you'd have to have one before you went, and you'd probably have one when you got back. I look back on it and it's all so obvious. But at the time it seemed like a life-style. I was stoned. It was a life-style.*

### ***Experiences of Mental Health Problems within the Women's Families***

When I wrote of the women's childhood experiences I included some family mental health problems, such as Anne's mother's depression, and Elizabeth's father's suicide following chronic depression. Elizabeth saw this family history as part of the reasons underpinning her own depression.

*I think I went a long time into, Oh 'Why me?' you know. Why does this happen to me? ..... Why did my father commit suicide? Why did this happen? Why did I have such a dysfunctional mother? And of course all those things make depression. Of course those are the things that have made me feel depressed.*

Isobel's mother and brother both attempted suicide and her sister spent time in a psychiatric hospital with depression. Ruth discovered as an adult that her mother was "*a bit low*" for most of her life, but "*never talked about it*". Linda's sister suffered severe anorexia. Hannah's grandmother had spent time in a psychiatric hospital with anxiety and "*neuroses*". Both Hine's parents were hospitalised, her mother with depression and her father with kleptomania. Anne, Chloe, Karen and Isobel all talked of their fathers as alcoholics and the impact this had on their daughters was discussed earlier.

Some of the women had partners with mental health problems. Chloe talked of one partner as being "*very alcohol dependent*" and of another having "*serious drinking problems*". Linda's marriage was under quite a lot of stress, and she was anxious and depressed herself and at some point realized that her husband also had difficulty coping and that "*he was actually suffering from very severe depression*". Kay's partner was in a car accident and they had to live with the effects of his closed head injury.

The inclusion of the parental and child stories seems to call on the particular medical discourse of depression that involves genetic factors. Both Hine and Elizabeth, however, suggested that they may have learned some behaviours from their parents, or

that their own issues may have stemmed from the experience of living with parents who had mental health problems. Ruth, Charlotte, Elizabeth and Christine all talked of having children with some diagnosed mental health problem, and although these experiences came after the disruption to the women's lives, they may have been told because they support the possibility of a 'hereditary' theory of mental unwellness.

## **Stress**

I have chosen to treat 'stress' related issues separately from mental health problems generally, because the focus in many of the narratives is on the contextual significance of stressful issues. Stress is talked of not so much as a 'jolly good reason' for being depressed, but as a barrier to accessing resources, such as child care or education. Access to these supports might have helped reduce the disruption of depression.

Katy is one of five women who talked of their financial situation contributing to stress. In her early married life, shortly before the first episode of depression she explained, "*we were broke, we were really broke...*". Kay also talked of financial things being very precarious just before depression disrupted her life. Hine talked at greater length about poverty. As she was growing up, and in her life as a single parent, poverty was important because it meant that she "*didn't have a choice*" about "*anything hardly*". Also she didn't have the resources to back any dreams she had. For a long time she and her children were living on food parcels. She believed that "*poverty is a huge kind of indicator*" of predisposition to depression.

Christine's story focussed on becoming a mother, but she also talked about the financial difficulties which prevented her being a full-time mother:

*I came back to New Zealand and started work, we didn't have any money. So I went back to work full-time. Launched in and – burned myself out. Did it for maybe two years and then crashed and burned.*

Fiona also talked of the stress of financial difficulties, especially the gendered situation of women trying to parent alone. When her marriage ended she needed to negotiate financial issues with her ex-husband:

*I'm still vulnerable to anything going wrong, and then when I get a bill that I can't pay, again my self-esteem crashes. I have to go back to my ex – he's got more money than you can poke a stick at. And I have to say to him, I've got a bill for \$311 .... Can you help me out? I can't pay these big bills on the benefit. And he pays them. And I get the old closed lip "Mmm I'll do that for you." And he does. And he never mentions it again. And he writes out the cheque and it's paid. But life should not be like that. It shouldn't.*

Kay also “loathed” “asking for money” and considered that was “one of the most diminishing aspects” of her relationship with her husband.

Employment and educational issues were another common source of stress. Marge centred her whole narrative on employment related stress. Her first severe episode of depression came when she started full-time work, and felt “*Oh, my God, I have to do this for the rest of my life.*” On reflection she considered that although study had been somewhat stressful, paid work in a responsible professional position was a major stress in her life. Marge was very well qualified, and had no difficulty getting high level work nationally and internationally. However, she found the work extremely difficult emotionally and “*performance anxiety*” is a central theme in her narrative. She was “*embarrassed*” by her inability to cope with work, and felt “*weak*” and that she “*wasn’t a strong enough person*”. She feared criticism, believing that was at the bottom of her anxiety about work. She had always felt “*very small*” partly from when her brothers teased her, and then from her perceived failure as a professional in paid work.

Whilst Marge was the only participant to centre her depression narrative around employment related issues, others found work issues significant. Fiona talked of unemployability as a sign of the enormity of her distress following her marriage break-up and her health problems.

*I’m not ready to work. I’ve still got to get my hip and my walking straight. I’ve got to get my emotions straight. And get my head back into a better place. For self esteem and for confidence to look for work. And to go and actually do it. .... I think I’m almost borderline unemployable, because I haven’t worked for so long. I don’t meet deadlines, I’m a bit unreliable, I get tired, I get impatient, I just don’t think I’m good material now. I don’t know what to do with myself. Because I’m fifty this year. And I think all that brains, and all that education. You know....*

Hannah attributes the second intrusion of depression into her life to the collapse of the family business. She talked of this business as “*turning over \$5 million a year*” and recalled that she and her husband had “*worked really, really hard to achieve this*”. She said that they had “*put everything back into the business that we’d worked for*”. They had lived a “*careful*” even “*frugal*” life. And then lost it through no fault of their own. She related the consequent depression to her feelings of anger and injustice:

*I think what knocked me there was I thought. It was the fact of the hard work. Because we had worked long, long hours to build that company*

*to where we got it. And then to just lose it all is just, very ... it was....and also I found the anger .... the anger ....*

Linda talked of work stress as a sub-plot in her narrative. It was connected with her low self-esteem and anxiety. “...it all started that year when I was on my own. Trying to make a buck. Struggling away.” The women who experienced stress in relation to education also often had concerns about performing adequately. Karen, for example was a great school student, achieving well and pleasing her parents. However, the possibility of being advanced a year ahead of her age group when she was in her late teens was very stressful.

*I knew I wouldn't cope with that..... I was kind of saying I can't cope, I've got crushes on half the boys in that class and I , I just know I can't cope socially, I don't want to be in their class, I don't want to have to work that hard.....”*

When Charlotte left her small rural community to go to university she suffered not only geographical dislocation, and isolation from family, but also became ‘other’ to her family by completing a degree:

*You see I was the first woman, I think person in my family to get a degree. In fact I was probably the first person in my, in my extended family to stay at school beyond fifteen.*

Ruth learned that stress increased her vulnerability to depression. She seemed to call on the diathesis/stress model of depression:

*... the stress levels in society, stress, stress, stress, burn out, and being female, working full time and then running a home, all those things. If you're not in control of those stress levels then you can get depressed. So it's all inter-related, it's all connected.*

## ***Lifelong Issues***

Some issues cannot be placed in any particular chronological part of the women's journeys. They come in and out of their lives at seemingly random times, or pervade life, but with different levels of significance at different times, or form a constant background to other matters. They are psychological, social, physical and existential issues, and they form the last section of this chapter.

## **Physical Health**

Few women included physical health problems in their narratives, but when they did they were significant. For Karen and Linda physical issues were central, and for Fiona

they were an important sub-plot. Lives are complex and many factors interconnect, so the physical issues of these three women have already been discussed in different parts of the chapter. In this section I will summarise these issues in relation to their being 'jolly good reasons' for depression.

Linda's medically related problem is the focus of her whole narrative. It impacted on her life in a major way. She did not tell me about this until some way into the interview, clearly because it caused her some embarrassment. When she first mentioned it she said:

*... It was a whole stream of things that happened at a similar time. And then I think the biggest, the biggest barrier for me in terms of things that I was worrying about most, was that I .... That I'd had a lot of sexual difficulties, sort of after I had been married.... I hadn't had any sexual relationships with any other boyfriends ....*

Linda sought help from her GP, who decided she was anxious and needed therapy, but did not give her a physical check. She said that she "*didn't feel very sexual*" and that it was "*so physically uncomfortable*" to have sex. It was "*awful*" and "*so difficult*". It reached a stage where sex was just "*not a part of our life*". She despaired of ever having children. It was many years before she discovered that her difficulties had a physical basis that could be solved through surgery. Linda also suffered from neck pain and head-aches, which professionals attributed to anxiety and stress. It was years before she was referred to a rheumatologist who said "*Well, you know, these are real physical feelings, you know. You are not a head case.*" Fibro myalgia was diagnosed and she was treated, the symptoms were reduced and remain well under control. Linda attributes her depression almost entirely to her physical problems, and to professionals' failure to diagnose them so that she had to live with the difficulties and also with the beliefs that she was 'mad' and that the pain and discomfort were all in her mind.

Karen's body and her disabling condition are often referred to in her narrative, not as a direct cause of depression, but as a constant contributing factor. Her distressing experiences with medical examinations have already been presented (p.144). She talked of the time when "*depression came into*" her life, when she was an adolescent, and connected this realisation directly to her experience of disability.

*I have a very clear memory of waking up one day with a hair brush in my hand, and banging my head very hard and saying "I am not happy, I am not happy, I am not happy." And I was about 16...and, I had been disabled since a very young age and thought I'd ----- really it was normalized to the nth degree. And, there was no permission to be*

*unhappy about it .... I was not going to be able to make this completely go away, the way I'd sort of been led to believe. If I did my exercises and went along with the faith healers and all that stuff. I did all that stuff and was a really good girl, and I kind of decided that this wasn't going to happen, and I was stuck with it. And I really didn't like it and I was never going to be like the others -----*

The disabling condition had many consequences. Karen was not able leave home, even as a young adult, because of it. Nor could she develop skills of independent living because her mother liked to work quickly, and so she never taught Karen, who was too slow. Karen also explains the physical exhaustion involved in managing a life with limited mobility, and the lack of independence and autonomy which often result from a physical dependence on others.

Fiona's physical health issues were the major sub-plot in her narrative. A childhood accident resulted in painful problems with her hip, which required a major operation just around the time of her worst depression.

*slowly but surely my hip, which had never been set or checked, it had always had a catch in it. That turned bad. It turned to arthritis, then it turned to osteoarthritis, and my damaged hip turning in its socket since I turned 40 got worse and worse and worse.*

Fiona was in agony in the time leading up to the operation, and needed pain-killers to walk up steps to the university and then more pain-killers so she could stand up and make dinner for the family. The months of recovery were very difficult. She lost her employment and suffered financial stress because of that loss of income, and because of the cost of the operation. For long periods of time she lived on the sickness benefit and felt as though she “*didn't have a hope in hell*”. Nine months after her operation she was still limping, and only then discovered that she had been given the wrong advice about going back to work, and about the need for physiotherapy. At the time of the interview Fiona described herself as “*border-line unemployable*”, in spite of her very high level of education and professional qualifications. She spoke of the interweaving of different difficulties.

*So here I am now. I've got two degrees and no job, and no confidence for a job. And I've got ....like....I'm still getting my hip straight. I'm still getting my head straight. I'm still emotionally vulnerable to anything going wrong.*



## Poor Self-Esteem

A sense of worthlessness pervades parts of all the stories, and was very apparent in the previous chapter. However, some women talked of having poor self-esteem before depression disrupted their lives. Chloe, for example, said she *“always felt rather insignificant”* and that *“I didn’t have a really good idea about myself”*.

Whilst, some of the women always thought poorly of themselves, others developed low self-esteem as adults, usually in conjunction with negative experiences. Thus Isobel reflects back on her life and concludes that during her seventeen years of marriage she *“lost my own sense of self-esteem”*. Jane also realised that throughout her marriage she had been insecure and co-dependent, and had *“wasted a lot of time sitting around feeling sorry for myself”*. Fiona talked of a time preceding her worst depression when she was discovering that her husband did not want to be with her in any way and she *“started to tail spin into this idea that I just wasn’t good enough”*. It is significant that these are the three women whose narratives focussed on the break up of ‘ideal’ marriages. The realisation of how their self-worth had been undermined within those marriages is part of their making meaning of their changed lives.

Kate, reflected on her unhealthy dependence on her friends with whom she *“just sort of swum on the current”*. Her lack of worth in her childhood was reflected in her comments about being sick as a child. She said *“I’d always felt that .... I wasn’t worthy of being sick, because I’d created the sickness, not that I’d picked up a germ from school or whatever.”* When she reflected on her adult life before the worst of depression, she again commented on her poor self-esteem. She realised that she had passed her jobless state off as not needing a career because she was *“always on the move”*, or because *“I didn’t want to be tied down to a job”*. However, when she was talking to me she commented:

*.... you, know, really I wasn’t worthy of having a job. And when I finally did get a proper job .... I spent the whole time after the first sort of three months, waiting to be sacked, because I couldn’t believe that I was doing a good enough job .... Even though my boss would just fall over himself, and say “God, you know, its so wonderful that you’re here, and I’m so enjoying working with you, and I always know when I give you stuff that it will get done.”*

## A Sense of Being ‘Other’

Many of the women talked of a sense of being ‘other’ throughout their lives. Karen realised as an adolescent that her disabling condition set her apart, and would always be there. Hine was also clear about the reasons she felt ‘other’:

*I thought that I had three children, I didn't have an education I didn't have a career, I was lesbian, Māori, on a benefit and couldn't drive*

Naomi talked of an otherness that had to be invisible.

*....blend in. Don't show that you're Jewish. Don't show that you're anything. Don't give anything away, because the world's an unsafe place and ... it'll be used against you. You'll be in trouble. So I learned so well to put on this façade. So it was both the Jewish stuff, the holocaust stuff. And it was also my parents. ...So I never felt accepted.*

For other women the sources of their experience of 'otherness' were less clear. Jane described an ongoing sense that *"my life was a little incongruent..... I felt I was on the periphery of life, looking out."* Her aloneness continued into her adult life. When she was flatting she observed her female flatmates *"botching up"* relationships, battling to be slim all the time and becoming involved in *"abusing substances"*, and knew that all that would have been too much for her. She knew that she couldn't *"knock myself around with emotions"*.

As Linda grew up two of her siblings were seriously ill for long periods, a sister with anorexia and a brother after a major car accident. Linda learned that she should not make a fuss about emotions, that they were *"superfluous to requirements"* and a bit *"flaky"* and *"self-indulgent"*. Any suffering she experienced should be endured in silence. So, when she experienced pain with sexual intercourse, she initially felt unable to complain or 'make a fuss'. Her otherness involved becoming 'invisible' like Naomi, but for different reasons.

Anne, Chloe and Isobel all experienced violence in their childhood homes and realised much later, that their families had not been 'normal'. Chloe said *"I just never felt right. I didn't feel normal"*. Isobel said *"It's only since I've been an adult and seen other kid's families and think -- well hang on a minute, I've missed out somewhere along the line."*

### **Awareness of the Depressing State of the World**

Many of the women realised that they found the world depressing. Katy said *"sometimes I feel the world very heavy on my shoulders, and I think its times like that. If I let it get to me too much, that's what can send me right down"*. Marge also commented:

*Sometimes I just had to protect myself ... I feel like the world is an incredibly horrible place to be in. And the violence and the people being so cruel to each other. People being cruel to animals. It bothers me all the time. Sometimes I couldn't watch the news. I couldn't go to certain movies. I had to stay with things that didn't reinforce the idea about how horrible people could be to each other. That was big.*

## **Conclusion**

In this chapter the women have explained what they understand to be the “jolly good reasons” for depression entering into, and disrupting their lives. Their explanations are complex, and they draw on a variety of ‘discourses’ to make sense of their past. Whilst these reasons, and their meaning within the whole narratives will be discussed in the final section of the thesis, there are some things worth noting now. The women’s explanations encompass a great complexity. They draw on intra and interpersonal understandings, on physical, biochemical, hormonal and hereditary theory. They have reviewed their ‘pre-depression’ lives, including for some, their heritage from past generations. They thought about metaphysics and poverty, about sexuality and employment. None of them found a single, tidy explanation for their distress.

If their “jolly good reasons” are read in the light of the dominant professional stories about the causes of depression some interesting features appear. The stories the women tell place less emphasis on the bio-medical explanations than one finds in the literature reviewed in Chapter Two. Where they do talk about a ‘pre-disposition’ it is often in cultural terms, such as Naomi’s calling on her Jewish cultural history, and Hine recognising the impact of her Māori and her lesbian identity. Many of the women also told of the negative impact of being female and having to live with the cultural expectations associated with gender. In a number of the stories the significant gendered aspects related to the cultural imperatives to be happily married, and a contented and successful mother. The stories that the women have created to make sense of their experiences of seriously disrupted lives draw on their gender and the expectations of society. Many of them have also retold parts of their lives where their expected journey was disrupted, either by geographical moves, by the ending of relationships or by their inability to live out their own intended life story. Marge’s failure to be able to manage the stresses of paid work in her chosen profession is a good example of this broken dream.

Although the women drew on some of the dominant contextual stories of cause, all of them emphasised the multi-faceted nature of depression, and all contextualised the intrusion of depression into their lives. In the next chapter I will present further complexity. The women talked about their learnings in the time before depression seriously disrupted their lives. They understand that while their vulnerability was growing, at the same time they held on to aspects of their own resourcefulness. The seeds of their resilience were planted, and they included them in their narratives.

## Chapter Eight: The Seeds of Resilience

Katy at boarding school, aged ten years

I remember lying in bed one night,  
and with the blankets over my head,  
and handkerchief stuffed in my mouth,  
so I wouldn't make a noise,  
and crying and crying and crying.

Wondering why people didn't like me.

And I finished crying  
and I started thinking.  
And I thought....  
What's wrong with me?

There's nothing wrong with me.

I may not be the same as everybody else,  
but I'm not –  
I don't have ten heads. I'm not spitting out of turn,  
or farting in the corridors,  
(excuse the language).

I'm sort of a quiet little girl.

And, if there's nothing wrong with me,  
and the good Lord made me this way,  
possibly he loves me this way.

So they've got the problem,  
not me.

Settled.

If they don't like it,

TOUGH!!!

I included in the previous chapter, the first few lines of this segment of Katy's narrative to illustrate her isolation. However, there was more to this story! As she continued the telling, Katy removed the handkerchief from her mouth, literally and metaphorically. She reclaims her voice, and can tell the 'cruel' girls that THEY have the problem, not ME! In this story Katy demonstrates how she has transformed what was potentially a narrative of loneliness and isolation into one of resourcefulness, resilience and learning. She draws on her humour, and her willingness, (and enjoyment) of being a rebel. She dialogues with herself in the self-reflective way that stands her in good stead for the rest of her life. Katy introduced herself to me as a "feisty old crone" and here she is telling us how she recalls displaying that independent, fighting, resilient, spirit when she was only ten years old.

Katy's is a vital story about enduring personal resourcefulness and its impact on her life and what it means to her. It is centred on a specific incident, which occurred many decades earlier, but one which Katy told with vivid detail. She used a lively, confident, tone of voice, and it was obvious to me that this was a story of strength. The meaning the events now had for Katy were positive, and they were able to be incorporated into the meaningful life she was living more than fifty years later.

All the women's narratives involved elements which seem to have been included because they helped to make sense of life beyond the disruption of depression. Often they are reflections on resources or resourcefulness which the women drew upon as they searched for and discovered meaning in their lives. I interpreted these parts of the story as the women talking about the building blocks of resilience; about the strengths which assisted their journey to recovery. They constitute a significant but not a large part of the narratives, and earned themselves a chapter in this thesis because of the part they play in the narrative of recovery. They are like threads of continuity woven into the narrative of the beginning and the recovery; threads which somehow survived the worst disruption and played a part in enabling the women to create a new and meaningful life which could still be linked/identified with the past, pre-disruption self.

### ***Positive Beginnings – Foundations for Resilience?***

All the women were able to develop, discover or rediscover a resilience which enabled them not only to find ways to move beyond the impact of depression, but also to resist

unhelpful ‘professional’ responses to their symptoms. They were able to find new ways to manage their lives, and create a new narrative of self in which depression no longer brought severe negative consequences. In all the women’s stories of their early lives there were hints about strengths to be revealed later. Only in the telling of the worst times, was it possible to forget the women’s strengths. They were not hopeless and helpless, and their stories about their foundations of resilience serve to remind us of the full complexity of their being.

The aspects of resilience I will discuss now often appeared on first hearing to be symptoms of depression rather than seeds for ‘recovery’. I needed always to remind myself to attempt to understand all the nuances, contradictions and complexities of the women’s journeys from their viewpoint. I also needed to consider why this particular episode or insight was being told in the narrative of the journey towards recovery.

### **Developing Coping Mechanisms**

Some women, especially those who had traumatic childhoods, talked about ways of coping, which they now believe, enabled them to survive the ‘worst times’. Naomi learned to “*dissociate*”. She describes herself as growing up feeling she lived with an “*empty pit inside*”. She managed to fill this with different things. Initially she became involved in things which were ultimately unhelpful, such as entering a violent relationship, and joining the Israeli army. As an adult Naomi realised that dissociation had prevented her from remembering much of the first eighteen years of her life. She came to a time when she could look at photographs and see that she was a “*gorgeous young thing*” – but she had no memory of what she was like or what she did with her life. She had been told she was a happy popular girl, but what she remembered was that she used to “*stand at the edge of windows in high buildings, and think about throwing myself off*”. Naomi told me that her ability to dissociate allowed her to endure the difficult years, until she could find ways to take more control of her life.

Ruth talked about how, from childhood, she needed to fill her life up with doing, and to use all her abundant energy because otherwise she would “*feel quite sad about things*”. She considered herself lucky that her mother recognised this need and encouraged her to do physical and creative things including swimming and drama. As Ruth grew into adulthood she learned to monitor herself and not get involved in what she described as things that would “*knock myself around with emotions*”. She continued,

however, to keep herself busy; for example, she “*medicated*” herself by doing a “*lot of exercise, almost to the point of being obsessive*”.

## **People and resilience**

### ***Mentors***

The women’s stories suggest that amongst the strong foundations for resilience is a sense of belonging with someone, even when family experiences are not supportive. Two of the women who had experienced difficult and traumatic times within their own families found people to live with in their late teens who offered them an experience of a ‘normal’ family. These adults had started off in a professional relationship with the young women, as teachers or other helping professionals, and then invited them into their own families.

Anne had at times found her nuclear family frightening. She spoke of “*the terror of that feeling of not being connected*”. In contrast, she found a ‘home’ as a result of her artistic talents and interest:

*I felt the experience of home for .... for the first time. Namely, the art department and that was the key for me ..... with the art teacher at the art department...I was invited to his place for dinner regularly with his family and things. So they were my link.*

Chloe, who like Anne, had lived a childhood with the regular presence of violence, also found a haven in her late teens. She left boarding school and went to live with a family:

*That was just wonderful. I enjoyed that, that was with a family. ... I felt it was like a normal family life. So, that was really helpful for me..... It was kind of like - so this is a normal family? So this is how people interact with each other?*

When Chloe undertook tertiary education in her early twenties, she again found a mentor in one of her English tutors who encouraged her poetry writing, and let her “*share my feelings and experiences in a creative way*”.

Jane’s mentor was an old woman who helped her to cope with a crisis amongst flat mates in her early adulthood. She came into Jane’s story as a wise woman who gave Jane advice that stood her in good stead in many of the future crises of her life:

*she told me, don’t get bitter .... Just talk to them about it, and don’t get bitter, and keep telling the bitter story.... It doesn’t get you anywhere. And I’ll never forget that. That influenced me actually. Yes.*



Karen did not live with her mentor but in her late teens she received a lot of support from her church choir master and his family:

*I belonged to a very liberal caring church. Quite different from what many people experienced in church those days. A very musical church and had a wonderful choir and superb choir master and we did music from all layers. Right back to renaissance music, you know really old music, and really new music and fantastic. You couldn't ask for a better introduction to spiritual music, it was just wonderful. And he was such a lovely man as well. And my Mum did his housework so we used to spend .... his wife was a very good friend of my Mum's and so we had a lot to do with the family, and really that's where culture came into my life. Through that family particularly.*

Karen experienced some other wonderful mentoring as a result of her musical talents and passions. One music teacher, a “*very admirable single lady*” pushed her to achieve and develop her talent to its utmost. Karen also found support and involvement amongst her wider family.

### ***Families and Partners***

Karen describes her family as “*great big like a Māori tribe family*” who were able to offer her a lot of caring. So, although her immediate family were often a source of stress they were contained within a much larger extended family that she was “*right in the thick of*”, and where she experienced caring with lots of music and humour. Also, Karen married and was able then to move away from her family and her home town, and make an independent life with the support of her husband. The enduring relationship with her husband, which started before her worst times with depression, was for her a strengthening resource for her recovery. Kate also had a very supportive partner, and he was with her throughout her worst times, and on into her undisrupted life. Marge was in a deep, caring relationship with her female partner throughout the worst times of her depression and this partner continued to play a significant role as she recovered. All three of these women are still in these supportive and enduring relationships. Six other women have been in lasting committed relationships throughout their worst times of depression and their recovery. Charlotte is one of these and she spoke not only of support from her partner but also from her wider family of origin.

Charlotte had the good fortune to have ‘culture’ come into her life through her extended family. She told of how she remembered that her grandfather, her mother and her aunt all modelled activities which have since become important for both Charlotte

and her children. She spoke of the value of living the traditions of the family, and how these learnings survived the dislocations:

*We play five hundred. Now, they learned to play five hundred by standing behind our chairs, when their grandparents came to play cards with us. I learned to play five hundred in the same way. And my father learned to play cards in exactly the same way.*

### **Friends**

Kate talked about friendship, but saw many of her early friendships as dependent relationships which were not good for her in the long run. However, her ability to make and retain friends was valuable later in her life when she developed a wider group of friends - “*a whole network*”. Naomi talked of a significant experience, as a young adult, with a group of women volunteers at Rape Crisis. This group gave her her first “*inkling of what acceptance was*”. Isobel’s marriage partner abandoned her, but her ability to make and retain female friends contributed to her resilience. She had an enduring group of loyal friends who supported her through her recovery. Hannah talked about her friends from work being at her side when she was most at risk. Chloe commented that she was always able to form good relationships with women, even when her heterosexual relationships were disastrous.

Nevertheless, as has been shown in the previous chapter, many of the women experienced loneliness, isolation and a sense of being ‘other’ in the early parts of their lives. For others friends are simply not part of their story, neither through their absence, nor through their support.

### **Pets as a foundation for resilience**

The stories of a number of the women suggest that pets create a connection that is very significant. Anne’s guinea pigs are a clear example of the impact of this.

*There’s another point of connection that I need .... I had animals. They were what kept me ... they yeah apart from my little cuddly sister .... I always had guinea pigs and the important part of having guinea pigs was that they responded to cuddling and I really needed that ..... and I took them ... it didn’t matter where we moved to and it didn’t matter what peer situations got disrupted as long as I had my guinea pigs.*

Marge included her cats as an important part of her story, and also recalled the significance of pet dogs. Katy now lives on a small holding with “*chickens and ducks and turkeys and sheep and goats and dogs and cats and pigeons, you name it I’ve got it*”. She has always had a strong sense of responsibility and respect for all “*God’s*

*creatures*” and even in her worst times she would drag herself out of bed to feed and care for her animals. Kate’s dog found her, and then was an important motivation for her journey out of her house and back into the world of human beings and social interactions. Although Elizabeth did not talk a lot about her connection with animals, her cat was a real participant in our interview, and she commented warmly about how pets had always been in her life.

### **Spirituality and meaning-making as resilience and foundations for recovery**

Throughout this middle section of my thesis the narratives emerge as multi-dimensional. The women included in their stories the inter-personal and intra-personal, as well as embodied aspects of their lives. Many also placed considerable importance on the spiritual, or trans-personal. For a number of women this interest in faith or meaning of life issues began in their youth, and was talked about as a positive resource.

Anne discovered astrology during her late teens, before her worst times with depression. Although she had found a sense of interpersonal belonging through teachers in the art world, she did not see relationships as meeting her needs at that time. Rather she recognised how well astrology met those needs:

*rather than looking to them in a relating way it was that desperate need to find meaning making systems and the astrological one was the one that I held onto like grim death ... astrology soothed me in those days, and also ...um .... Yep.... It was mainly astrology then and then later on it became psychology and alchemy and myth and all those other meaning-making maps*

Karen “*really needed*” her Christian beliefs to “*keep me stable*” and has called on her belief system all through her life. Katy talked throughout her story of her life long Christian faith, which has been a key support for her. Linda wove her faith subtly into her narrative, specifically telling me that “*my husband and I are both Christians*”.

Hine found that when she was young, there being a “*spiritual sense to myself was just really natural*” and that she was “*probably naturally quite clairvoyant.*” She talked about her teens and early adult life in terms of being separated from her “*good self*” and her “*god self*”. This separation lasted throughout her times of worst depression, but the spiritual interest had been there all her life. Hannah has also had spiritual beliefs that have helped her throughout her journey:

*I've had difficulties, obviously, to walk through. But--- I mean what other people walk through. Very hard. But without that spiritual awareness, let's put it that way. I would have found it a lot harder.*

Ruth knew since early in her life that she had a “*highly developed sensual system*”; a gift that she believes some people would call “*psychic*”, but she chose not to use that word. She told me that both her grandmother and her great-grandmother recognised this gift in her when she was very young, and when her mother was close to death she told Ruth that she knew about her gift, and that it had skipped one generation. Other people in her life had recognised this, including old women in a Māori community where Ruth worked. She saw it as something she was comfortable with most of the time, but when she was “*low*” it could also be “*scary*”.

### **Intellectual and Creative Activity**

Many of the women had a wealth of personal creativity to sustain them through the difficult parts of their life journey. This took different forms, but was often talked of as significant. Other women realised at some point in their life, often as adults, that they were talented intellectually. The gender bias that blocked many of them from moving easily from adolescence into tertiary education, did not prevent this intellectual ability from surviving. It became a resource that played an important part in many women's recovery.

### ***Creativity***

Anne is an artist and photographer, having discovered this creativity in her teenage years, and creativity remains a significant resource in her life. Chloe “*wrote a lot of poetry*”, as did Naomi. Isobel found music her salvation. She said:

*It's always been my salvation when my father's been ready to beat me up, or anything else, I would take myself off and play my music..... if I was allowed to ..... or just listen.*

Karen said “*music has always been, and probably always will be one of the things that gets me through*”. Hine is a singer and a poet. She described herself as “*multi-talented*” and considered that her intelligence, her creativity and her ability to teach all enabled her eventually to work towards achieving her dreams. She talked of her awareness that her richness of life experience and her intelligence are not available to “*all women*”. Hine knew she was fortunate to have had these resources of resilience.

### ***Intellectual and Academic Abilities***

Fiona discovered her intellectual and academic capabilities when her children were teenagers, and before her marriage ended. She had gone back to university to finish a bachelor's degree and did so well that a friend suggested she should try a professional degree. She did so and found that she was good at that too. She said "*I was so busy and I was so proud of myself, and I was feeling my power for the first time.*" Fiona was amazed at this because at school she had not achieved well. This academic success did not prevent depression from having a major negative impact on her life, after she had started at university. Her intellectual abilities have, however, been a resource she has been able to call on at times when life has been very difficult.

It is noteworthy that all but two of the women in this study finished up with tertiary qualifications at some point in their journey. It seems likely that all the women in this study had intellectual resources to draw on from a young age. These may not have been fostered formally until well into their adult lives, but the abilities were probably always there.

### ***Reading, Learning, Understanding, Being Intellectually Prepared***

Many women used their minds and their ability to think and plan to cope with hard times. This quality is well illustrated by Jane's story. She reflected that she needs "*to be one step ahead of difficult situations*". She practised this throughout her life, especially by reading and going to courses. She cited the example of "*reading before my children became teenagers about adolescent problems*" and predicted that she will "*be reading about old age before I get there. And how to make the most of it ....*"

Jane had to deal with a lot of losses in her life. Interestingly she did not include these in the story of her journey into depression, but as contributors to her ability to cope. In her narrative the early losses were talked about as opportunities for learning coping skills. As a pre-schooler she was cared for in a children's home for nearly a year, and later by her grandmother for two years, because her mother had TB. She looked back at the photographs of herself at that time and noticed how unkempt and uncared for she looked. Her mother died when she was only 11 years old, and her grandmother died shortly afterwards. A flat-mate died suddenly, and a brother was killed in an accident. She discussed all these losses and concluded by saying "*then my ex-husband leaves me – that was the ultimate loss*". When she was talking of her brother's death she said she realised "*we're strong, we've dealt with death before*".

Karen delighted in learning, and described herself as “*hugely curious*”. Katy learned to value what she could learn from books, and from observation, when she was in boarding school and friendless. As was illustrated in the opening to this chapter, she decided that the girls who didn’t like her had the problem, not her, and she added “*it was at that point, if I’d never been a reader before I really became a reader.*” From her observations of pupils and teachers she also learned “*a very important lesson..... that not all grown ups are adults. They’re simply bigger and older than you.*”

Hine considered she had the advantage of a “*variety of exposures*” in her “*unique upbringing*”. Her mother was “*bright*” and “*talked with compassion about a lot of different subjects*” which freed Hine up to “*think quite eclectically and quite laterally about a lot of things*”.

Some women had very specific learnings which they recognised as valuable and sustaining. Katy did not have a long formal education, but learned about homeopathy very early in her adult life. Kate also was fascinated by alternative approaches to health, and learned massage in her twenties when her depression was at its worst. Both these women found these interests were very relevant in their later life journeys.

## **Ways of Being**

Some women talked about fundamental personality characteristics which they saw as enduring throughout their lives. These positive attributes were included in the stories as survival qualities. Kate, for example, described herself as always being “*reasonably confident*”. Katy was certain that her feistiness played a significant part in her journey through and beyond depression. A large part of her beginning story focussed on her love of life. She said “*I think I’m bloody-minded. I’m very strong willed and if I was going to sell myself up I’d say I’m an idealist*”. This was not a recently discovered quality. As was shown in the opening of this chapter, Katy talked about it being there when she was ten, and surviving the hardships of boarding school life.

Ruth acknowledged her ability to get through lots of trauma because “*I’m strong*”, but she also saw her strength as her “*greatest weakness*”, because it diverted her for years from acknowledging that she was depressed. Fiona talked about the ways of dealing with things in her family as strengths that she learned, and that formed a foundation of resilience:

*In my family, if you want to cry you bloody cry. If you wanted to argue you argued. If you had a bone to pick, or a difference of opinion that was fine. You just had it. You know. If somebody did something that*

*offended someone they just said so. You know. And you had it out there. And then you forgot about it.*

## **Conclusion**

In this chapter it has become apparent that these were a very resourceful group of women. They were able to call on a range of skills and insights to help them move through their lives, even when the times were very difficult.

In the next chapter I will present the searches for solutions to the disruption depression brought into their lives. In some cases the solutions they try are disastrous; in others they are simply not helpful. Sometimes they actively seek options themselves; at different times they are forced by other people to try particular potential remedies. Throughout Chapter Nine there will be glimpses of the resources that have been introduced in this chapter.

## Chapter Nine: Crawling Out of It is So Hard

### Chloe seeks a way out

And so I went to the doctor.  
My local doctor,  
to tell him about this sleep thing.  
Cause I didn't think I would get through the Christmas.  
I didn't know how I was going to cope.  
And, he was going to put me on ....  
It wasn't Prozac then,  
what was it?  
Because I took it home.  
He had a sample bottle in the ---  
What the hell was it?

I remember thinking.  
I'm just not going to get into that,  
I'm not going to take medication.  
So I went across the road to the umm,  
the health food shop,  
and asked to see a homeopath.

Because I thought I'll try the homeopathy angle.  
And, so, I saw her, and she put me on this particular.  
These little tabs.  
I had some of those,  
and I remember the experience...

After these.  
I don't know if it was a magical thing  
or what it was in myself.  
But I remember the day it happened.  
It was very sunny day  
and I was wearing a red sort of top,  
and I felt the blackness lift like that.  
It was like something quite physical,  
a whole black cloud --- and I remember feeling euphoria....  
I'd never felt ---  
I just felt, it lifted.  
It was just like it had been a great big sort of lid over me,  
and somebody took it off.  
And it was just,  
I couldn't believe it.



And that was only the beginning ,  
because after that,  
then it was (sigh)  
facing myself really.

I knew I was a depressed person  
and I knew I had major issues ----

I have called this chapter “Crawling Out of It is So Hard” because Hannah used these words when she reflected back on her journey. This title reminds us that there is no “quick fix” to the distress she has been suffering, but also suggests that there might be a way out. Chloe’s words, presented in poetic form, tell of some of the processes involved in discovering a way out. Her distress was becoming unbearable so she followed the most readily available advice and went to her GP. When she got there she talked about a specific and acceptable element of her distress – “the sleep thing”, rather than the bigger, holistic experience of misery. Chloe’s GP prescribed antidepressant medication. Although she remembers even the clothes she was wearing when the black cloud lifted, and gives us vivid images of this ‘magical episode’ she speaks very briefly of the episode with the doctor. She gives no hint of any consultative process, appears to be compliant, and meekly does as she is told. She takes the pills away without argument. The telling of the story demonstrates women’s silence in the presence of the expert. Straight away Chloe knows that she is not going to use the medication, but she does not tell her GP. Instead, she is spurred on by the incident to seek relief elsewhere. She takes control of the situation, goes straight to the health food shop and asks to see a homeopath. It is as though the response of her GP, which she found so unacceptable, enables her to act in a way that is more in keeping with her own values. She then tells the story of the magical lifting of the black cloud. Chloe’s story does not, however, end here. She immediately talks about the complexity and deep significance of her experience with depression. She recognises that whilst her symptoms have been relieved, and she has made a good decision for herself in seeking a homeopathic cure, nevertheless, she knows there is still a long and difficult journey ahead, exploring and dealing with ‘herself’. Chloe acknowledges the complexity of finding a way to journey beyond the serious disruption of depression.

I have written about the worst times for the women (Chapter Six), of the jolly good reasons they talk about for depression disrupting their lives (Chapter Seven), and about their resilience (Chapter Eight). These form the beginnings of the stories of recovery; each having a significant part in the overall patterns which emerge. The patterns will be discussed in the final section of the thesis (The End; Chapter Eleven). The present chapter (Nine) and the one that follows (Ten) are, however, the heart of the thesis. They focus on the women's experiences of recovery. In Chapter Nine I discuss the women's stories about attempts to move on. In Chapter Ten I present the women's stories of Getting the Formula Right; their understanding of the most important aspects of their achievement of recovery, and how they came to live lives no longer seriously disrupted by depression.

Chapter Nine shows how the women's stories reveal that some of the potential 'solutions' they tried made things worse and others had a neutral impact, but all of the women found ways to begin "to crawl out". I focus on the characters and their actions within the stories. Alongside the narrative and critical analysis this chapter is at times purely descriptive.

### Structure of the Chapter

The structure of this chapter is complex and the analysis is multi-layered. I have discerned three important issues that intertwine in the stories, and which I present in this analysis. They concern;

- the **stages** of the journey towards recovery,
- the **nature** of the pathways,
- the way that new directions were **initiated**.

In Chapter Five (p.102) I presented a table explaining the process I followed to analyse the data for this part of the women's journeys to recovery. I reproduce this table here.

	<b>FALSE STARTS (Stage One)</b>		<b>BEGINNING TO CRAWL OUT (Stage Two)</b>	
	Initiated by		Initiated by	
	Self	Others	Self	Others
Medical				
Psychological				
Other				

**Figure Four:** Analytic grid for 'Crawling out is so hard'

### *Stages of the Journey*

One aspect that has emerged from my readings of the narratives is to perceive the journeys as involving three stages. These stages emerged from the data, but not in the neat and sequential way they are presented in these two chapters. What I have called Stage One involves **false starts**, and these occurred for many women before Stage Two during which the women find things which help them to **begin crawling out**. Kay conveys the complexity of these times as “*three steps forward, three sideways, one back*”. Finally, in a third stage, each woman discovered a set of responses that worked for her. She got **the formula right** and achieved a life no longer seriously disrupted by depression. Chapter Ten will focus on this third stage; the formula that each woman found worked for her.

### *Nature of the Pathway*

The second set of issues is critical to the research question and concerns the ‘kind’ of strategies that the women have tried. Some strategies seem to be connected to the dominant medical or psychological discourses, different strategies seem to be ‘other’ to these mainstream professional solutions. The women volunteered to participate in the study because they had found ‘non-professional’ solutions helpful to recovery. These ‘alternative’ pathways form a significant part of the stories analysed in this chapter. As with all the analytic decisions, there are no clear binary distinctions between mainstream and alternative pathways. I have used the following guidelines, which have emerged from contextual and linguistic cues within the women’s narratives (as well as from my own ‘narrative habitus’) to decide how I would present different responses.

**Medical:** Strategies or pathways involving practices from within the ‘medical’ discourse and often recommended by a mainstream medical professional, including GPs and psychiatrists. These pathways usually involved ‘treatment’ administered or controlled by medically trained professionals, such as antidepressant medication, electro-convulsive therapy (ECT) and, at times, hospitalisation. In many cases it has been easy to decide which responses belong in this category. However, an example which was difficult to classify was Isobel’s interaction with her GP. She describes this as follows:

*My doctor was wonderful – my GP. He’s just a honey. He’s just lovely.... And he talked a lot to me. I just talked to him just as a friend. I used to go there and burst into tears in his office and I used to – you know – like I said – “You’ve probably been the biggest help”.*

I have decided to include this example as ‘interpersonal’ rather than ‘medical’ because although the central character interacting with Isobel in this story is a doctor she highlights his ‘friend’ quality, much more than his professional ‘medical’ expertise.

**Psychological:** Responses categorised as psychological are those which are clearly informed by the psychological discourse and the ‘psy’ society. They have usually been recommended or administered by a ‘mainstream’ counsellor, psychologist or psychotherapist and include personal, couple and group therapy. The distinctions between mainstream and alternative psychological therapies are often blurred, and where the decision has been particularly difficult this will be commented on. In the light of my own ambivalence, it is interesting to note that the women who participated in the study did not seem to have any trouble deciding which parts of their journey involved ‘professional’ solutions, and which were ‘other’.

**Other:** These paths are the hardest to define; they include all those responses which the participants talk about as ‘other’. The richness, creativity and variation of behaviours, beliefs, ideas and thought patterns included in these parts of the narratives will only become apparent as the next two chapters unfold. Linguistically ‘other’ often has connotations of ‘less than’ and it involves being on the margins, yet for these women the ‘other’ pathways are those which featured centrally when they finally got ‘the formula right’.

### ***Initiation of New Pathways***

Within each journey stage new pathways were initiated in a variety of ways. Often the woman talked of initiating the new direction herself. However, possible solutions and treatments were at times suggested or imposed by family, friends or professionals. At times the new direction came as a result of ‘happenstance’ with no intentionality apparently involved.

It is not always clear who initiated a response, but I have tried to discern where the woman has placed the responsibility for the proposed ‘solution’. The responsibility is different from the issue of ‘agency’. I will use Chloe’s story from the beginning of the chapter as an example. In that story Chloe demonstrated considerable agency in deciding to visit her GP, then deciding not to fill the prescription, and then choosing to seek out a homeopath. The ‘responsibility’ for the suggestion of antidepressant medication, however, lies with the GP. A further thread which is woven into the analysis presented in this chapter involves the idea of ‘resistance’. At times agency

emerges as a resource available to the women within a context of their resisting the pathways offered by the dominant discourse.

### ***Doing Nothing and Agency***

The major part of this chapter is structured around the issues just outlined. However, I will start with a section concerning a common initial response to the disruption of depression; doing nothing, or just carrying on. There will follow six sections representing the intertwining issues.

Agency was seldom apparent in the women's first reactions to depression. At this point the most common reaction was one of disbelief, or minimising, and other people around them echoed this response, or 'non-response'. The women just tried to get on with their lives and hope the distress would go away.

### ***"I just sort of lived with it"***

Many women recalled that although they were aware of their distress and perhaps used the word 'depression' to describe what was happening, initially they "*just sort of lived with it*". This situation could last for weeks, months or years, until it was interrupted in a variety of ways.

Kate, the youngest of the participants, described herself in her teenage years as "*just*" being a "*moody person*", a description she had been given by teachers, family members and friends. When she looked back, however, she considered that all through those years and her early adulthood her feelings and behaviour "*weren't moods, they were actually the onset of depression*". Nobody, however, suggested that help might be appropriate or available and she believed "*this is just something that I live with*". She thought back about the failure of adults to recognise what was happening and said:

*It just, it never kind of got questioned.... At the time I was thinking --- Yeah, I thought very strongly that was bad. That nobody picked it up. That nobody picked up .... That I was allowed to go on for, like fifteen years, and no one ever really queried it. I mean, if you'd been limping or dragging one foot, someone would have noticed. But because it was emotional it was just all brushed aside, and you were expected to cope. Mmmm. Or even if you'd been out there beating people up, in an aggressive kind of way??? Or become a total drug addict.... Because it was only yourself that was being damaged.... I mean I guess so many people go through that, I mean I think that most people do go through at least a stage. But fifteen years! Fifteen years is a long time, and I do feel that I missed out....*

No-one who could make any difference recognised Kate's suffering, and she believed it was normal. Similarly Anne saw nothing unusual in her adolescent experience, and adults failed to recognise her distress. She talked of living through her teenage years in the "*normal mode*", but realising later that she had been "*completely unrelated to the world*".

Other women tried to keep going in their adult years, and were either not ready or not able to acknowledge that what they were experiencing might not be 'normal'. Charlotte, for example, did not experience depression until after the birth of her first child, and for a relatively short time she tried to just keep going. She was a successful professional woman, with a good education and in a supportive marriage. Not surprisingly she "*had this idea that I could manage by myself, and I wasn't necessarily ready to acknowledge [the depression]*". Christine also found her life significantly disrupted by depression after the birth of her first child, but she chose for a long time to do nothing. She reflected on how things might have been different if her parents had been in the same town, but decided that "*I don't know if it would have mattered ... because I was going down, down the road, and I was not going to be deviated from that.*" For six months she just went on, and recalls with some bewilderment in her voice: "*I didn't, I didn't do anything. That's right.... Didn't do anything.*"

Elizabeth did nothing for a while either, and part of the chaotic 'and then, and then, and then' disruption of her life involved feeling overwhelmed but believing "*I've got to carry on, I've got to carry on, I've got to carry on*". At the time of her interview she had realised that she may have carried on because she had no way to find help. She said "*just before I was twenty .... In those days I think that I was suffering from considerable depression, and I didn't have anyone really that I could turn to....*". Naomi also carried on, even when she was "*visibly depressed*". For her, carrying on meant being "*busy, busy, busy, busy, busy*".

In the circumstances and contexts described in this section it seems that, as the women recall, they were not ready or able to recognise 'depression' and they were not resourced to act against it themselves. Nothing happened because there was nobody else who was prepared to act on their behalf, even when they were children. When they did begin to try solutions, they all experienced at least one false start.

## **False Starts**

In this section I will present some of the ‘false starts’, and the women’s explanations of why they did not work, or why they needed to be supplemented by other pathways. The majority of the false starts fit within the medical or psychological model. It was unusual for the women to talk about ‘other’ responses that didn’t work.

### **Medical**

The most common recommendation for women experiencing depression is that they visit their GP<sup>5</sup>. It is not surprising, then, that the GP was the first port of call for many of the women in this study. A few women found their GP’s advice very helpful, but most were advised to take antidepressants, and many felt this medication was not acceptable. Chloe, whose story about rejecting medically prescribed drugs introduces this chapter, did not give reasons for her decision. Others did and the explanations most frequently offered were a preference for focusing on the causes of the depression (the ‘jolly good reasons’), and a dislike of the ‘side effects’ of medication.

A number of the women talked of their belief that taking antidepressant medication would prevent them from addressing the issues which had led to depression. Anne, for example, was in regular therapy when antidepressants were suggested for her. She said:

*Hell, there were a couple of times when there was an option for medication, but I was already so impassioned about psychology I knew that this was my big chance to live and I wasn’t going to take the route of medication because I didn’t want to have to revisit all this later. Not to this extent anyway. This was my big chance.*

Elizabeth also talked about making a specific choice to focus on the causes of her depression. Her story was similar to Chloe’s; her doctor prescribed Aropax, she had the prescription filled, then took it home, looked at it and thought “*No, this is not what I want*”. She understood that depression had come into her life in the context of a lot of “*stuff that I was going through*” and believed that she could “*get out of this myself in other ways*”.

Other women did not talk specifically about choosing therapy over medication, but rejected medication because it could prevent them from experiencing their ‘real’ feelings. Kate talked about medication giving her “*altered perception*” and she felt that

---

<sup>5</sup> In Aotearoa New Zealand free mental health services are “secondary” and are only available and funded for 3% of the population. They therefore require a ‘primary’ service referral, except in emergencies.

since distortion was part of depression anyway, she did not want further alteration artificially. Naomi said she had always been “*quite quick to reject*” the possibility of medication, preferring in spite of the “*bad bits*” to actually “*feel*”.

Many women who elaborated on their reasons for not taking medication talked about the unacceptable “*side effects*”. Some described how the drugs affected their minds. Charlotte, for example, went to her GP because her husband found he was unable to cope with her “*not really functioning at all*”. Her husband said “*for heaven’s sake, why don’t you go and see the doctor*”. The doctor diagnosed post-natal depression and prescribed antidepressants. Charlotte found the side effects terrible:

*--- everything felt grey. It felt almost as though I was disembodied. My mind was sort of floating up above there, and in .... nothing was really real. So it was still grey, and dead. Like having cotton wool packed around my mind.*

Charlotte chose not to continue taking this medication, and it was some time before she found other, more satisfactory options.

Other women talked about unacceptable changes in their body. Isobel, for example, was very specific. The ‘side effects’ prevented her doing the most important things in her life. She could get out of bed, and didn’t cry so much, but the quality of her life once she was up was not worth having:

*They levelled me out but I started feeling nothing and I just. I wouldn’t feel. And then my hands started shaking and I couldn’t play the piano which was my salvation and that was something I could really just lose myself in with my music and I couldn’t play because my hands were shaking something dreadful. I couldn’t do my cross-stitch, I couldn’t think.*

At times the women’s concerns focussed on mistrust of the prescribing doctor. Linda at first had antidepressants prescribed in too large a dose. She felt sick and “*couldn’t sleep*” and was “*high as a kite at night*”. Christine and Hine both commented on their concern over the risks of taking antidepressant medication when they were pregnant or breast feeding. They felt that the prescribing doctor had not taken all the relevant factors into consideration. Hine was quite cynical about her experience with medication. She had “*valium and all sorts of things*” prescribed when she was in her late teens, after the birth of her first child. She seldom took them, but stored them until she had “*containers full*”. She chose to tell me a story to illustrate the risky possibilities of medication for herself and her young children:



*I'll tell you a funny little story actually. This psychiatrist gave me, I can't remember the name of it, but he gave me some medication to take and I was pregnant. Now, this druggie came and stayed with me. He was a dealer actually and he was a hardened druggie. He used to use cocaine and all the rest of it and he saw this stash of stuff I had in the cupboard. He said "Would you like me to take that and get rid of it? I could probably get you some money for that on the, you know the black market sort of style. And I said "Sure you can take it" knowing full well I probably wouldn't get any money. Any way he rang me a couple of days later to say that he'd taken some of this medication that this bloody psychiatrist had given me while I was pregnant and he said he ended up driving on the wrong side of the road and parked in somebody's driveway he didn't know to sleep it off and I'll never forget that. I mean, this is a well person, who's got a high tolerance to drugs and no wonder it blew my bloody head off and here I was like 22 you know. I wasn't very large at the time, I was pregnant, heavily pregnant then and that's what they'd given me and I hadn't taken it because it spun me right out and it nearly bloody killed him and other people on the road.*

Christine's story is less dramatic, but she also was shocked to be offered strong medication by a doctor she described as "useless". She talked of her concern that "*he didn't piddle around, he went straight to the sharp end*". He prescribed imipramine without taking into account that she was breast feeding, and the only other choice she was offered was institutionalisation.

Even when the women did not specifically mention medication they at times felt that their GP had nothing to offer them, or worse, that they were neither understood nor valued. Charlotte, for example, found that the GP she first visited "*didn't really know how to handle it*", and Kay felt betrayed when she discovered that her GP had talked with her husband behind her back, and they had decided together what "*your wife needs*" although she knew that "*some of it was not what I needed*". Christine took herself to the doctor as she could see things getting "*worse and worse and worse*". She was reluctant to criticise the doctor directly, but pointed out the inadequacy of his response when she said "*he was OK*", but immediately qualified this with "*he probably should have looked deeper, and scratched the surface*". Elizabeth also went to her GP on a number of occasions but he "*never suggested that I might have been depressed*". Her doctor just dealt with physical issues, many of which she now knows were fabricated by herself as excuses to visit the doctor. She moved cities and went to a new doctor, but he "*shifted it into "Oh well it's just you know, women's stuff, it's just a*

*hormonal thing....*” Elizabeth found this hard to accept when the doctor knew that her father had had a chronic depressive illness and committed suicide.

The final story about false starts from the medical model concerns hospitalisation. Four women experienced time in psychiatric wards or hospitals. Hine had two stays in a psychiatric hospital during her teens and early twenties, and as she left the second time a charge nurse said to her *“I’ll see you within five years”*. This judgement made Hine very angry and she recalls;

*I made a promise to myself I would never go back there. And when there were other times in my twenties when I felt quite crazy I did other things, but I never went back there.*

Karen had many different experiences of hospitalisation, some of them helpful. Her first visit to hospital, however, occurred in her late adolescence, and was clearly a false start. She describes the experience as *“absolutely frightful”* because they *“didn’t know what to do with adolescents”*. She also had ECT, and whilst it was not *“really bad stuff like Janet Frame had”* it did leave her with a *“huge sense of disorientation and a feeling that my memory, which never felt particularly good any way, was even worse. Like less reliable ...”*

Chloe was referred to a hospital based group after a serious suicide attempt, but she found it unhelpful and terrifying. She perceived it as a place for *“obviously people with mental illness”* and although she told me she had forgotten *“what sort of people were there”* she remembered clearly that she thought *“I do not belong here”*. She turned away from this pathway but for many years did not access any other support, which she came to regret, since she stayed feeling *“deeply unhappy”*.

The experiences in hospital often included psychological as well as medical treatment, and some of the unhelpful talking therapy treatments will be examined in the next section.

## **Psychological**

False starts within the psychological model were many and varied. The most straightforward was when women rang a service such as Lifeline, and were unable to get an answer. This happened to both Kate and Katy, and Jane got someone on the phone that she describes as *“an absolute dweeb who didn’t tell me anything”*. Naomi had a similarly unhelpful experience with a telephone Rape Crisis service. She rang after her husband raped her, but they assumed she was ringing to become a volunteer.

She found herself unable to tell them they were wrong, and actually became a volunteer instead of a client. Fiona went to a group at a community house which was unsuccessful because there were three different facilitators in three weeks, and then the numbers attending dropped to three. Fiona was promised that she would be contacted about a new group, but that never happened, so she never sought counselling or groups again.

Another apparently ‘simple’ reason given for false starts in counselling or therapy was a mismatch of age or gender. Isobel talked about seeking help from a community mental health centre, but found she *“had some girl as a counsellor”*. Isobel was the mother of teenagers and her husband had left her and had an affair, and she felt quite unable to discuss these issues with this young woman:

*I thought you don’t know anything I need. You’re just too young and I just said to her “Look, I’m not coming back”. I said “I feel as if I’m helping you rather than you helping me”.*

Hannah had concerns about issues of sexuality within her family, and she had a counsellor who was *“very young”* with *“no life experience”* and she believed this person gave the family some really bad advice. Katy found the hospital based crisis team completely ineffective, because *“they were young enough to be my kids”*, and on a different occasion she was allotted a male therapist who was *“kind”* but *“did nothing”* for her.

When the therapy was for a couple, it was possible for the woman’s partner to sabotage the process, and Fiona gave an example of this when she described her husband being *“so disrespectful”* to the counsellor. Isobel’s attempt at couple counselling failed because the counsellor did not initially reveal that he had already worked with Isobel’s estranged husband and his new ‘girlfriend’. Isobel felt betrayed and unable to trust the counsellor or the process.

There may also be a perceived mismatch of style or personality, or the therapist may be experienced as simply ineffective. Chloe was allocated a Jungian therapist after a serious suicide attempt, but found that they just *“didn’t connect at all”*. Jane went to couple counselling as her marriage was breaking down, but found the therapist not *“very effective”*, because he *“just listened”*. Hine went to many different counsellors before she found effective help, and she is quite angry with the lack of perception of *“those bloody counsellors”*. She now believes that her journey would have been very different if someone had recognised her intelligence and potential for education much earlier. These counsellors not only failed to recognise her potential, but they also were

unable to give her the “*kind of one-on-one nurturing attention*” that she needed. Ruth saw a counsellor who had “*some good ideas*” but “*she’s not a human being*” and so Ruth stopped seeing her. Karen had helpful psycho-dynamic therapy over a number of years, but her earliest experience was not good. She was in a psychiatric hospital and was allocated an “*extremely Freudian chap*” who she describes as “*appalling*”. She was very young, but she took charge of these compulsory sessions:

*In the end all I could do was talk about art and literature and history and he would glaze over and it would shut him up and I’d just prattle on to the end of the session. Then I’d be able to go away. So it was pathetic. I mean I’m sure it made me worse.*

A more complex mismatch involves the theoretical approach or modality of the therapist. Participants who had trained as counsellors or therapists were frequently concerned about a lack of ‘depth’. Naomi, for example, recalled that her first counsellor questioned her about abuse and anger, and “*got that so wrong*”. The result was that although Naomi did feel for the first time that a professional was “*present*” for her, she did not feel safe to continue to see her. She had false starts with other counsellors later, because the work:

*doesn’t manage to get down into that soul, you know, place inside. That place inside that probably started many generations ago. And it just sits there. I have this vision of it somehow. It’s a little acorn, you know, inside.*

Marge used a similar phrase to describe unsatisfactory experiences she had with therapy before she found a psycho-synthesis therapist. She “*hadn’t found other kinds of counselling as helpful*”. In her experience they didn’t really get “*into your soul*”. Kate tried counselling which she found supportive, but “*not enough*” when compared with the “*depth work*” she did with a different therapist. Hine recognised that many counsellors could be “*empathetic*” but lack the “*real skills to shift you into being able to be proactive about your life*”. The group therapy she had in hospital was “*superficial*” and her therapist there admitted that she saw Hine intensively for three weeks, but was unable “*to get close to anything deep-seated*”.

Sometimes the therapeutic approach was really helpful, but the timing and practicalities were not appropriate. Karen at one time had Jungian therapy which had helpful aspects, but did not suit her for many reasons:

*The analyst said to me “that’s great. We’re really getting to grips with what’s really going on”. But I thought “Yeah. But my whole bloody life is going down the tubes, you know, all the things I’m trying to do aren’t working. And she was even trying to tell me to leave my husband, and to drop some of the stress, our relationship was so unhealthy. So – that was pretty grim, it was very grim actually.*

Kate found a counsellor who was potentially helpful, and she realised that “*gosh, I could change this around*” which was “*a bit of an eye-opener*”. She had to stop attending counselling, however, because “*we didn’t have a lot of money*”. This was clearly a disappointment for her, and she told me about it with a big sigh.

The most disturbing example of a psychological false start comes from Linda. The central issue in her narrative is that she had an undiagnosed anatomical issue which made sexual intercourse extremely painful, and ultimately impossible. This impacted hugely on her marriage, her self-esteem and her mood. She visited her GP who did not give her a full physical examination but decided that she was “*a head case*” and referred her to a psychological therapist. The therapist she attended for the next two and a half years decided that Linda had a lot of “*old stuff*” that needed to be “*waded through and gone over*”. Linda felt that this approach to therapy, for her, was “*not very helpful*”. Linda was very angry:

*It had always been talked about in a head way. That I had some sort of problem with having sex or something.... Some of the stuff that therapists come up with.... makes me so angry. I just think, how can you drop that onto people, and sort of imply that just because they can’t do some physical thing, that there’s some emotional correlation to it. And I .... OH!!! ... I still have times when I feel angry about it. And how dare they, how dare they ply you with information and then leave you feeling so gutted. Leap to conclusions without realizing what might be going on.*

Linda and her husband also went to couple’s therapy, but again had a very bad experience, where the therapist implied that “*people who hadn’t had some sort of sexual experience in their life before they were married ... must have a problem*”. Both Linda and her husband felt misunderstood and belittled.

When Linda reflected back on these experiences of therapy she realised that she had spent a lot of money and time over more than two years. She was still unable to have a sexual relationship with her husband and she felt no better about herself. In fact, she believed that the “*intensity of an hour’s therapy*” with this particular person was “*really dangerous*”. She came out feeling worse than when she went in:

*I actually felt that was just like sticking a stick into a wound full of pus and just saying “well, I wonder what’s actually in here? Before we put the plaster on we’ll just have another poke around and never really allow any healing.”*

## **Other**

Suicide attempts were a common response to depression. Twelve women seriously considered ending their own lives, and many made actual attempts. I will not repeat the details here, since they were presented in Chapter Five (pp.118-121), but need to acknowledge that such thoughts and actions were prominent in the stories of unhelpful attempts to deal with the distress of depression.

Another very common ‘non-professional’ false start involved the women’s attempts to manage their distress with alcohol or non-prescription drugs. Kate explained this approach, and its failure:

*I have these huge kinds of ups and downs, and the downs are really quite bad, and I’ll just mask it with lots of alcohol and, and dope, and party drugs, recreational drugs...”*

Chloe also spent many years drinking too much and eating in a way she now considers very unhealthy. Naomi also failed to take care of her body, and when she looked back considered her unwise eating, her lack of exercise and her smoking all to be signs of her avoiding dealing effectively with the ‘jolly good reasons’ that brought depression into her life.

Another common ‘false start’ involved attempts to fix life by making a geographical shift. Such environmental changes worked really well for a number of the women, but not for others. Moves to another country were seldom made just to find a way out of the context that had led to depression. For Naomi, however, this was the case. Firstly she moved to Israel, and joined the army in the hope that it would make her life more meaningful. A few years later she moved from Israel to New Zealand to escape a violent marriage and hopefully to become less depressed. Neither move worked. Marge moved countries to find a different working environment whilst staying within a career she eventually abandoned. The move did not help her to combat her depression.

Some women comment on ‘alternative’ therapies they tried, which were not helpful. Katy, for example, went to a hypnotherapist, she found the process wonderfully relaxing, but the therapist advised her to deal with the stress she experienced on social occasions by going out to such events more often. She related with wonderment that

*“his advice was to actually do it. To actually do what I least wanted to do.”* She decided that this advice was *“stupid”* and refused to follow it. Kate was similarly unimpressed by the advice of a kinesiologist.

At times well intentioned friends, family or professionals offered advice which was not followed or felt to be inappropriate. Christine for example, was advised by a psychologist to get someone in to help with her baby so she could get out of the house, but she told me she had sabotaged this plan by sitting in the house with her, or just running up to the dairy and back for five minutes, but never really taking a break from worrying about her baby. Ruth’s mother told her daughter that she should *“be more physical”* or perhaps do something *“expressive or creative”*. On reflection Ruth could see that this advice came from her mother’s understanding of her, but at the time she rejected the wisdom because she needed to make her own decisions and be *“free”*. Marge also commented on advice to exercise, which in her case came from reading self-help books. Her view of this advice was very cynical:

*They say things like, you know, exercise. So, I think, really you know, when you’re depressed the last possible thing I want to do is exercise. Maybe there’s somebody out there who does, who you know that works for them, but ... it’s like.... Who feels like jogging up the road when you’re depressed? You have to worry about it. It just sets up another ‘should’. Well! Oh God – I’m feeling horrible, I should go for a walk up the road, I might feel better. But then it’s just another should.*

Christine also tried reading self-help books but found that she hated them. She explained this reaction in a way that emphasises the complex understanding many of the women have reached of themselves, their distress and its ‘remedies’.

*Why do I hate self-help books? That’s a good question. Because to make shifts in yourself, for me, the shifts are so small. And every tiny shift takes so much work, that in some ways you set yourself up to fail. The books almost make you fail. And I’m not. And often they’re very behaviourist, and I’m not. That’s not my way. I really have problems with it. You read the first chapter and you think, Oh, - I’d better get that into place. I’d better make some cards and write things on them, and say them to myself, and you know, that kind of thing. Very simplified. And working on yourself is a, is a huge developmental process.*

Fiona and Marge both recognised that there were times when doing the professional work they were qualified to do was not the healthiest option for them. Friends, however, tried to encourage them to pursue their careers. Fiona’s friends saw a job they

thought would be wonderful for her, and would help to lift her out of depression. They said “*you must apply for it*” but Fiona had to find the courage to resist their advice and trust her knowledge that she was not ready for full-time paid work.

Some advice was not well-intentioned. Isobel’s husband, for example, told her for years “*you are just crazy, you need psychiatric help ... you should be locked up*”. This advice and the associated fear of being labelled as ‘mad’ contributed to Isobel’s delay in seeking suitable help for her distress. Her depression was triggered by her husband’s affair and his leaving her for another woman. When she looked back on that time she believed her husband was labelling her as “*mad*” to “*justify*” his own behaviour.

### ***Beginning to crawl out***

After a number of false starts the women all began to discover responses which helped them to recover. These discoveries came at times from the medical and the psychological worlds. A significant feature of the narratives was that at this stage all the women began to discuss ventures into alternative, non-professional pathways and responses.

### **Medical**

Many of the women who sought help from their GP found that they were offered some kind of medical treatment, usually antidepressant medication. Whilst many found it inappropriate and unhelpful, there were some who found that medication enabled them to begin to crawl out. None of the women talked about hospitalization or ECT as helpful.

### ***Medication and symptom relief***

Fiona’s story, which follows, is not unusual. She told of the welcome symptom relief provided by medication, but was ambivalent about taking it. She called the medication a “*chemical safety net*” and resented the side effects of “*nausea, interrupted sleep, stimulated appetite and weight gain*”. Fiona constantly weighed up whether having the safety net and losing some distressing symptoms was worth it. She protested at times to her doctor, and reported saying to him “*What’s wrong with me feeling my feelings? Why not just crash when I’m going to crash? Till I learn not to, or till it goes away?*” He convinced her, at least temporarily, that it was better to move out of her state of being immobilized so that she could begin living “*to her full potential*”. However, she



still wavered about the decision, and was not convinced by his expertise. Fiona reflected *“I won’t be immobilized .... Maybe, maybe not. What does he know? He’s never had a thing go wrong with him....”*

Other women found that medication helped them find the energy to start doing worthwhile things. Hannah, for example, was put on a course of Dilantin by her GP. He recognised that her distress was partly the result of Hannah being *“married to a man that – you know you are poles apart”*. The medication helped her to *“cope”* as a young mother, go out to work, and deal with issues related to her childhood and birth family. She didn’t want to stay on the medication for any length of time, because she knew *“that the drug did change you, chemically”*, so she worked hard to find other things to manage her depression so she could limit the time when she experienced this chemical alteration. Reluctance to take medication was common. Jane finally accepted what she feared was an *“addictive drug”* when her doctor persuaded her that it would *“calm”* her and that it was *“like a stress pill”*. Her doctor did make it a condition of the medication that she also go and get some therapy, and Jane benefited from this combination. She described herself as *“the perfect antidepressant client”*. Kay also found that medication helped to stabilise her *“mood swings, sense of anxiety and tearfulness”* and even better, it enabled her to have her *“first decent sleep”* after her daughter was born.

Ruth talked of the positive and negative aspects of antidepressants. She took Aropax for a year, and experienced a *“marked difference”* which was really positive, but still didn’t feel she had *“control of myself”* and was glad when she could stop taking it. It had allowed her to sleep, but had other less attractive side effects:

*Aropax was going to do it. But – other side effects. You don’t feel very sexual, which for me is a bit of a bummer, because I enjoy being sexual, the sexual act, very much indeed. So I went off that.*

Hine’s story offers an example of the dilemmas involved in trying to artificially categorise things. I am categorising so this thesis has a meaningful narrative sequence, however aspects of the women’s stories do not easily fit. Hine’s experience with antidepressant medication is hard to fit. For her the psychological effect of antidepressant medication is more central to the story than its ability to provide symptom relief. She talks about her use of medication in this ‘crawling out of it’ stage as something which ‘kick-starts’ her into a renewed effort to do something proactive, and to start *“fighting”* again. It does provide some symptom relief, but it featured in her

story because it was so unacceptable to her as the 22 year old mother of three young children. She reacted against it as soon as it relieved her “paralysis”.

*When I had these dreadful tablets they kind of made me feel worse physically and it would help me start fighting again. They were awful. I thought, I can't do this. I can't function properly. I can't look after my children properly. But I was grateful for them because they took away what I was having which was being kind of locked into this paralysis of you know I'm not going anywhere, I'm dying, sort of style.*

The medications themselves are sometimes not as important as the person prescribing them.

### ***Finding the right medical person***

Ruth's medication was prescribed by a female GP whom she found by chance, and who took time to listen to her story and not just treat the sleep problems Ruth had given as her reason for coming. Ruth was relieved to be told she had “*probably had low grade depression all her life*”. Her post-traumatic stress was also recognised. Many of the women talked of the person who offered medical treatment as a central character in this part of their story. They valued feeling understood, and mentioned the good luck of finding the right person. Thus Kay describes how she went to a Women's Health Clinic and had a “*doctor, a lady doctor*” and then had support from a “superb” Plunket nurse:

*She was the only one who would hug me, and say “this ... its OK to be where you are at. And it will get better, I can promise you that”.*

Jane had the good fortune of meeting a female doctor: “*I'm so thrilled that I went to the one I went to – my own GP is a male, but it was a woman who saw me.*” The ‘right person’ was also an important part of the stories about psychological help which enabled the women to begin to crawl out.

### **Psychological**

Professional psychological help was much more significant than medical help, and it came in a variety of forms. Some women found therapists whose individual counselling was right for them, others discovered therapeutic groups that were valuable. Sometimes the progress was very tentative, hardly a movement at all, but the women acknowledged that they were beginning their journey out. Sometimes the stories emphasised aspects of the process of a ‘talking cure’, others put more emphasis on the relationship.

### ***“Sitting down and talking to a stranger”: The process***

One aspect of the process that was valuable was how it enabled the women to talk about their situation, to be heard and understood. Linda found through counselling a way to cope with her anxiety, and this enabled her to travel overseas. She explained how she thought this had worked:

*Well I think when you actually have to sit down and talk to a stranger about a catalogue of events which cause pain. It does help you to see, when you've condensed it like that, gosh, you know, there's a whole lot of horrible things that happened. And it does legitimize the way I'm feeling now.*

Kate also acknowledged that finding a counsellor and being able to “talk about it” really did help.

Within the process, one third of the women commented on the value of having their distress recognised and named. Anne explained: *“I appreciate how diagnostic categories can be damaging, but for me it was the most important thing.”* One positive aspect of naming for Anne and others was that it let them find out more about depression through reading, thus enabling them to understand themselves better. Ruth discovered a psychiatrist who told her *“I think you've had low grade depression most of your life”*. Ruth experienced this psychiatrist as being *“inhuman”*, *“not a human being”*, and *“very intellectual”* and she was disappointed that she never recommended therapy, and knew she *“wasn't enough for me”*, but the explanation she gave was useful:

*She was very useful in explaining things, summarising things and everything else. She said “you can jump up and down and feel really high after exercise, but when you come down again it shows the brain isn't producing enough.” And I went right into it, and I read through all the books.*

Another way that naming the problem was helpful was that it enabled women to face up to the reality of their own distress, and at times to their involvement in it. It stopped them blaming other people, and when they recognised their ownership of the ‘problem’ they could seek ways to manage it, and to begin to ‘crawl out’. Chloe described this situation:

*I was able to tell him [her husband] exactly how I was feeling and – we were sort of struggling and we went for counselling, again, the two of us. And it became apparent, to my horror, in the counselling, that I was the one with major issues. So I had to face it, to accept it. So I kept going to see this guy, and he had been a doctor. I'm not sure how*

*qualified he was, looking back, but anyway, it shook the cage. It got me started .....*

Kay also had her cage shaken by a counsellor. She was encouraged to keep a journal, and this enabled her to be “*very negative, very honestly*”. Then she could see “*quickly*” her own “*negative spiral*” and she realised that there had to be a “*circuit breaker somewhere*”:

*When I looked back at what I'd written in the cold light of the following day it was – I was – moan, bitch, whinge, transfer, negativity. And you know that journal was helpful, it also had to become a tool for moving away from where I was. And so quietly and progressively over time those sorts of things helped.*

Elizabeth also talked about a growing self-awareness, through personal development work with a therapist in the nineteen seventies. She became more “*alert*” to her feelings and emotions. She was “*starting to get a little of a contrast. This is this, and, oh, this is this – more self-aware.*” She spoke of this growing awareness as a beginning of her ‘crawling out’.

Isobel’s experience with naming was different; she began to recover when a psychiatrist told her she was ‘normal’. For years her husband had told her she was ‘crazy’, and when he left her for another woman and Isobel became extremely distressed and attempted suicide her husband considered this proof of her insanity. She was in hospital after taking an overdose and a psychiatrist came to see her in the mental health unit. Isobel felt recognised as a human being of worth by the psychiatrist, and the relationship was important as well as the normalising. She comments in wonder about her response to this ‘professional’:

*I was just so unhappy that I just didn't know how to cope any more. It was just a lack of coping. It was wonderful when he said “you're not mad, you're just very sad”. Just unhappy. That was wonderful and he was gorgeous. And I remember looking and thinking how can I stare – in this hospital gown, in this bed, at this psychiatrist and think he was gorgeous looking. It's just things like that that just retain a .....*

### ***“Sitting down and talking to a stranger”: The relationship***

Isobel’s experience of being a valued human being in relation to the psychiatrist was rare, but not uncommon. As with the medical professionals, the relationship between the women and the psychologist, counsellor or psychiatrist was important. For Isobel, there were two valuable professional relationships. The one with the psychiatrist was

brief, but significant. The other was with her GP, and lasted over many years. She described this relationship in the way that many women experienced a good counsellor:

*My doctor was wonderful. My GP. He's just a honey. He's just lovely. He's ... ummm .... He talked a lot to me. I just talked to him. Just like a friend. I used to go there and burst into tears in his office and I used to .... You know, like I said "you've probably been the biggest help"*

Christine had a significant professional relationship with a female psychiatrist over many years. The meeting with her signalled the beginning of Christine's 'crawling out'. She was referred to the psychiatrist by a GP who recognised that she was experiencing more than her own diagnosis of "really bad PMT". The special understanding of Christine as a woman was important:

*...she doesn't just give you medication. I can't remember what she does. She does a lot of talking, a lot of challenging your thoughts about why you think this way. That is, she is very woman focussed. She, I think now she only works with women, but she's very woman focussed. She must have had faith in me. ....We had a relationship, and I wanted to please her, and I wanted to do what she wanted me to do. And so I did it.*

What Christine 'did' at that point was to take a little time for herself every day, away from her children. Some years later the same psychiatrist helped her to bond with her newly born child by giving Christine "a stern talking to" and making her look at her baby, even when she didn't want to. The advice worked because of the strength of the relationship.

Women talked about professional relationships that worked in very personal language. Karen said of one counsellor "he was a wonderful chap" and this was "the first time really that I'd had any thoughtful kind of counselling input into my life". Later at a psychiatric in-patient unit she met a "wonderful --- Freudian doctor" who was "open-minded" and "just what I needed". She worked with him for three months in a place she describes as "an amazing experience, sort of like a finishing school for the creatively mad".

Linda also started her recovery through meeting a therapist with whom she could really relate. She had previously had a very bad experience which was described earlier (p.195), and was not ready to trust a therapist. This second therapist convinced her. She was:

*....willing to discard some of the sort of traditional boundaries of therapy, she would actually talk about her life. Her family, her husband. Make some confidences, knowing that I wasn't about to tell*

*the world. I found that quite re-assuring, because I also felt it was reciprocal. It was grown up.*

### **Group work**

Some women found a sense of being understood in groups. Kate's self-esteem group was run by a Women's Centre. It was an "eye-opener" for her, and helped her realise that she could "change this around" perhaps by visiting her family and friends on the other side of the world, or by going to therapy. Unfortunately for her, she could not then pursue either of these paths because "we didn't have a lot of money, and it all seemed like too much hard work". She did, however, gain some important insights through the group:

*We did something on anger, and I could actually feel the, the block in my throat about even talking about it in this group. That there was obviously something that was lurking that I couldn't even put words to. I just thought that there was lots of stuff that I haven't talked about since I was a very young person.*

Karen went to a very practical course at a unit based within a mental health service. She found that it was "a good facility" which "taught me some really basic skills like relaxation training, and time structuring, all those cognitive behaviourist things I'd name them now".

### **Professional support to leave an unhealthy relationship**

Naomi found a group experience by chance. She was seeking support for herself because she was in a violent relationship, but because of a misunderstanding she finished up being a volunteer counsellor at the Rape Crisis group she had rung for help. This experience of being in a training group with other women was wonderful for her, and along with a "bit of counselling" it gave her "enough energy to pack my bags", leave the relationship and the country. This move gave her a base to start her journey of recovery.

Hine and Marge both went to counselling which enabled them to leave unhealthy relationships. In Hine's case she found a feminist counsellor who began her on "the journey of finding out who I was, and my wellness, and my sexuality". As a consequence, Hine left her husband and started the "slow journey of meeting other feminists and other gay women". Marge had already been in a lesbian relationship for some years, but it was not a good relationship for her. The relationship involved a lot of

anger, and “*as part of the therapy I sort of identified the anger thing, and got rid of the anger, and ended that relationship*”.

I have shown the importance of the relationship with the professional. Relationships with other people are also a significant feature of many of the stories of alternative solutions. These ‘non-professional’ things hardly featured in the ‘false starts’, but here, as the women tell the stories of their beginning struggles to crawl out, such alternatives to mainstream treatment start to feature as a major element of the narratives.

## **Other**

The stories of the worst times had many similarities, such as the frequent reference to being ‘curled up in a foetal position’. In contrast, the stories of the journeys out are characterised by the variety of the experiences which have been helpful to different women. These include stories about people, relationships, activities, beliefs, thoughts, and contextual changes.

I will begin with contextual things, move through aspects of interaction with others, including family, then to cultural activities and those of the mind. Responses directly related to ‘doing’ will come next. As with all the other findings, this structure is imposed and the boundaries between different sections are blurred.

## ***Contextual matters***

One of the ways that the women enacted their awareness that change might be possible was by bringing about changes in the context of their lives. I have mentioned relationship changes made in response to the advice of counsellors. For Naomi this ending of a relationship also involved a major geographic move from the northern hemisphere to New Zealand, a country she had never visited, and where she knew no-one. She was seeking a place of safety, but knew that her choice of destination would leave her with no known people to support her. Naomi talked about her decision with no regrets, admiration for her own courage, and surprise that she was able to do it:

*That was fleeing, I mean, boy. I look back at that and I think, ---- because I mean by this time, you know, there was this violence going on and I'd taken out an injunction order --- and oh my God he was following me, and --- I was sick. I was vomiting up. You know, it was horrible, it was horrible. It was absolutely --- it was a nightmare, it was a horror movie. At this point--- but somehow I must have got enough little bits --- to have had the strength to extract myself from it. And run, flee to New Zealand.... I knew I had to get out .... I somehow*

*knew inside that I would be able to get support, get more support in, in a place like here. You know I didn't go back to my parents. I went to a new country. I think, I look back now and I think, My God, (laughs in wonderment).*

Chloe also made a geographical shift away from a situation of risk. Her move was within New Zealand, but it enabled her like Naomi, to find new and different supports, and to begin to re-build a safer and healthier life. Karen moved within New Zealand to strengthen her marriage because she knew that with her disabling condition she would struggle to be independent from friends and family if she stayed in her home area:

*I felt, if we are going to make a go of it, we've got to get ourselves out of here. And that was very much me. I mean, I do seem to have this ability to see some things very, very clearly and insist on taking action on them.*

I explained earlier that many of the women came to New Zealand before depression disrupted their lives, and some considered this immigration part of the reason underpinning their depression. Amongst this group, some chose to visit their country of origin as a step towards a healthier life. Marge, for example, moved backwards and forwards twice between her birth country and New Zealand. Hannah returned to the UK to be with her parents, leaving her husband and small children in New Zealand. She knew at the time that she had a simple choice; *"I could have gone to [psychiatric hospital], because I knew I was really at dead low. Or, I could have gone to the UK. Home to the parents."* She chose the latter, and resolved some long-standing issues with her mother while she was there.

Linda took a trip overseas from New Zealand at a time when she had been very anxious, and quite dependent on her family. The trip signified an important stage of her growing independence from her family:

*I took myself off overseas for six months, which is the bravest thing I've ever done. I was twenty-two .....It was quite important for me to do something ..... surprise everyone and be a bit more tough. And that was a hard time, but it was a good time for me.*

Elizabeth also travelled overseas, but for her this was not so much a brave adventure, as the beginning of a very significant journey of spiritual awareness. She had married young, and had small children whom she left behind with her husband:

*I had to go. There were no two ways about what was happening. And I just had to get completely out. I mean, I married young, I had my*



*family, never travelled, never sort of ... and I just had to go, and I went (laughs). And I went to France, and I spent a lot of time in France. I went by myself and it was a really powerful time for me .... Getting in touch with sort of spiritual things. I went to .... I mean churches found me, I didn't find churches. I would just ... I .... Every church I could find I was in. And it was hugely uplifting for me. And realising that aspect of my life was ... that was the start of the journey. It was something that was really deep down. Really deep.*

When Elizabeth returned months later to resume life with her family she was ready to begin a new stage of her life.

Geographical changes make a major difference, but there are other contextual changes women can make. Karen, for example, organised her life with her husband differently so that she could increase her hours of sleep. She preferred to wake up about five hours before him, so they decided to have separate beds available for when they needed to sleep without waking each other. Karen knew she was much more likely to be depressed if she let herself get overtired. Fiona's re-organisation of her life was different. She was living on her own with her children, after her husband left them, and she decided one day to change the garden. She describes this activity and what it meant to her:

*I started doing homely things. And I started to rip out the horrible overshadowing fir trees that lined the inside of the garden. They were dark, and they had mosquitoes underneath them that would come out at night and bite us. And I cleared the section, so this is very symbolic isn't it?*

Fiona's story illustrates how nothing fits easily into any one category. Her story is on one level about physical activity and changing the environment and physical context of her life, but on another level, not far removed, it is clearly a story about creating a new and different meaning in her life.

The physical context within which life is lived can be influenced in significant ways by one's financial resources. Hannah knew she needed to get back to the UK to see her family, but as an unemployed mother of very young children, in the 1960s she had no way to make this happen. She decided to ask her estranged husband for the money, and fortunately he agreed to help in this way. Hine was also a single mother of young children, and in her case money was needed to provide more food for the family than "*rice three or four nights a week and marmite sandwiches for lunch*". Hine decided to get out of what she spoke of as a "*financial trap*" and she worked really hard to do that. She commented that "*poverty is a huge kind of indicator that people*

*can be predisposed to depression*". Kay expressed a similar belief when she commented on the birth of her second child. She had become very depressed after her first child, but this did not happen the second time. She believes this was in part because by that stage they were *"financially secure"*. The practical implications of this were that she could have help with housework and child care, and that she had a car to transport herself and the children. This financial security provided a context within which she felt less vulnerable to depression.

### ***Interpersonal and relationship***

Many of the contextual changes just presented took place within or because of relationships. People are ever present in the women's narratives; they were involved in the 'jolly good reasons', but also in their 'crawling out of it'. I have discussed the significance of the women's relationships with medical and psychological professionals. I will now present stories of mentors, kindred spirits, friends and family. The most powerful of these stories belong in the next chapter. There are, however, important stories where relationships provide the key which enabled the women to begin their recovery.

**Mentors:** Mentors have appeared by chance in the lives of many of the women. Elizabeth used that term specifically when she talked of a family for whom religion was *"very, very, part of their lives"*. She described this family as *"wonderful"* and on looking back realised that they *"became a very strong focus for me – you know like mentor type people"*. Her own family were not involved in anything spiritual, and yet a spiritual awareness became an important part of her life beyond depression. She came to see how this early mentoring created this possibility in her later life.

Karen had a variety of mentors who facilitated her spiritual, emotional and cultural development. One was a *"superb lecturer"* who was *"not just an academic"*. Karen thrived on his teaching and loved it. She finished up having an extremely successful academic year, and not having any mental health *"blow ups"* which had happened in each of the previous three years. She also had exceptional people in those years who mentored her in cultural things, especially music, and in her spiritual development. Anne had a mentor in her cultural world who was an *"anchor"* for her through some of her worst times. She considered that without him and another high school teacher/mentor, and later her therapist she would have *"either been dead, or institutionalised"*. Chloe recognised as a mentor one of her teachers at tertiary level. He

fostered and praised her “*creative*” side, and this support gave her some seed of self belief later in life as she struggled with depression, enabling her to believe she might find ways to move on and grow.

**Kindred Spirits:** In more personal relationships and communities, many women found ‘kindred spirits’ who offered them acceptance at the most difficult times of their lives. Frequently they discovered this kinship within women’s groups, often with a focus on voluntary work related to women’s issues. Kay met women through ‘playgroup’ and considered that they enabled her to “*regain some of my former self*” as she was slowly progressing with a “*gradual three steps forward, three sideways, one back*” movement. She considered the women she met “*key for me*”. Hine joined a Women’s Centre, and did voluntary work with Rape Crisis, as did Naomi. Naomi explains what this feeling of being amongst kindred spirits was like for her:

*That was when I got my first inkling of what acceptance was. When I sat in a group of women for the first time in my life.... and I remember saying, some tiny little thing about my experience with my husband. And there was something someone said, or something the group.... You know there was something that happened, like “that’s not OK, and you, you are OK”. Something like that. It was the first glimpse of --- so I think I saw that my healing could take place. ....Being part of a group that accepted me as its member, really.*

Years later, as she recovered, Naomi found another group of kindred spirits in a university course. Again she saw them as “*an accepting family*”. Karen found acceptance within a university spiritual and social action group and expressed feelings similar to Naomi. She was delighted that “*they treated me very, very much like a person. So that was very healing*”. This experience was duplicated later in another city with a group who shared a love of music. Later still Karen lived within a “*mind expanding and wonderful*” community for over a year. Hine found her kindred women in a perhaps more surprising way. As a young woman she was hospitalised because she had been diagnosed as having depression, and she found these “*wonderful women*” who were the other patients in the unit. She experienced “*friendship*” and “*nurturing*” in a way that was entirely new to her, she found that they were “*generally worse off than me*” and that she was able to help them. She summarises that experience as: “*It was incredible, and I actually left feeling so much better*”.

**Friendships:** Individual friendships and the support and understanding they offered were another level of relationship which enabled the women to begin their

journeys. Sometimes this happened for women who saw the ending of a relationship as one of the reasons for depression. Fiona was one in this situation, and she found renewed hope and direction when she reconnected with an old school friend from twenty years earlier. He contacted her when he heard of her marriage breakdown and initially was “*just a friend*” who would drop in often for coffee. He began to look after her and to talk with her and became “*a saviour*” because he understood how “*devastated*” she was, and was there for her:

*I realised how much he was supporting me, and I felt overwhelmed with gratitude for him because he got nothing back for it. You know. He didn't. He just did. He saw a huge need, and he just came in.*

Even her children noticed that for the first time in ages she “*had a smile on her face*”. He did very practical things, as well as offering understanding. She talked about how, after she had a major operation in the midst of her worst depression, he:

*Went and slept in the trundle bed and he didn't mind. And every morning he'd get up about six and he'd come in and he'd put on my stockings and I could get up and go to the loo, and he'd make me a hot chocolate and toast and then he had to leave for work.*

Jane, Isobel and Hannah also talked about very special friendships which were both practical and understanding, and which helped them to move on after the ending of significant relationships and the resulting experiences of depression. In these early stages this friendship was often talked about in terms of practical, real and consistent help. Like Fiona, Isobel had friends who helped her dress. She was immobilised by depression, and her friends would ring her every day to check how she was. When she couldn't stop crying and found it hard to get up and dressed these four friends came round and helped her shower and dress and took her out to lunch, even though she had declared “*I don't want to see anybody*”. Jane had a loyal friend who rang her “*every Friday night*” over a period of nine months and who listened and understood.

Hannah had a friend who recognised her unspoken intention to kill herself as she drove home one night, confiscated her car keys, and made her stay with her overnight. The next day the friend drove Hannah home, and she knew that her life had been saved and how “*wonderful*” this friend was. Later, another friend helped her “*get the money together to go to the UK*”. A good friend of Marge's set her on the road out by recommending a really good GP to her when she became aware that she was experiencing very debilitating depression.

At this time, close to the worst disruption, being understood was very important in many women's stories. I have already discussed how significant it was that they felt understood by professionals and mentors and the relief of finding groups of like minded people. It is not surprising that understanding friendships were also able to 'kick start' the women's recovery, even when the loss of a significant relationship was not a part of their story. Elizabeth had a close and supportive family, but commented on friendships where she could talk about her experience of depression with a woman who had similar experiences. She found this "*really helpful*" and explained that this friendship enabled her to begin to break out of her isolation.

Sometimes friendships offered 'fun'. Linda talked of a holiday she and her husband had in the tropics with another couple, where she "*wasn't coping internally*" and felt "*so low*". The other couple helped them to "*carry on*" and have some "*really nice experiences*":

*I managed to be sufficiently charming for these people to want to be interested in us. And I think coming back after having felt so low, maybe, that it's worth kind of carrying on, because you know there are some very nice experiences to be had out there. And I don't want to keep missing out on them. And I think when you're really low, and you don't experience pleasure in any way, there's not a lot of motivation to seek out pleasure.*

Karen talked of her "*closest girlfriend*" at a time not long after she had been in a psychiatric hospital for therapy and ECT. The friend had "*a brilliant mind, and we used to have fun*". Chloe also spoke of a "*really strong friendship*". She remembered that "*we both loved to dance, and have fun. And in a way I think she saw a good side of me, and I really responded to that in her.*"

**Family, including pets:** All the women mentioned their relationship with family members as significant to the start of their recovery. I am including grandparents, parents, siblings, partners and children as family. I will start this section with the comments of three of the women about the family pets and their role in the journey.

Anne recognised the significance that pets can have when she talked about the guinea pigs in her childhood. They had been given to her by her grandparents, and they provided a stability that was important in her disrupted childhood. They also "*responded to cuddling and I really needed that*" she said as she recalled the lack of physical affection from the humans in her life. Later on at a very difficult time in her

life she had a “*little stray cat*” that she could care for. Katy has many animals on her small holding, and at her worst times they gave her a reason to get up and leave the house, because they needed to be fed and cared for. Kate was found by her dog, which turned up one day on her doorstep. This dog was present at our interview, and was spoken of in the warmest way. Kate recalled how she had needed to take the dog for walks even when depression and agoraphobia were at their most disruptive. Kate says of the dog “*I often look at her and think, you know, she saved my bacon.*”

Hannah got through a really difficult time by leaving her children with her estranged husband and travelling to the other side of the world where her sister’s home provided her with a “*haven*” within which she knew she was “*safe*” and where she “*didn’t have to be concerned about anything*”. Marge’s brothers had at times put her down, but one of them did pay for an overseas holiday for her to give her a break the first time she experienced depression.

Karen did not have any siblings, but she too found a safe haven at difficult times within her extended family, especially her grandparents and her cousins. She knew that her grandfather “*really cared*” for her and her grandmother collected magazines and gave her a place to go when she was thoroughly exhausted; a place where she could “*lie in bed for hours and read*”. Her relationship with her mother was more intense, but it was the thought of the impact it would have, if her only child committed suicide, that kept her from killing herself at her moments of greatest despair.

Many women talked about their children as their reasons for staying alive, when death was very tempting. Naomi, Isobel and Katy all say this explicitly. Katy explains:

*I’d really thought very, very seriously about suicide. But I had these two little kids and even in my worst times I never believed that anybody else could love them as much as I did. So while they were part of the reason for me being depressed they were also my reason for coming out of it.*

In some situations the women’s children were proactively involved in supporting them. Jane wanted to be strong for her children, but also she was very aware of the support her daughter offered. Her daughter “*never wanted to see me cry again*” and she acknowledged that she owes this daughter “*a lot of credit for my healing*”. Charlotte’s son was only a toddler when her life was seriously disrupted by depression, and she was able to use her wish to relate to him as a way of keeping herself going.

*...so I would say things like “Hah! Well son! In a minute we’d better go and wash the nappies. And he’d say “OK. Come on. Come on.”*

*Because he was only two. So we'd do it (speaking enthusiastically)  
and that – that kept me moving.*

Whilst some of the women were on their own, and had been in very unhappy relationships, ten had caring and supportive partners throughout the time that depression disrupted their lives. Christine, Marge, Kate and Linda all talk specifically about the role of their partners in their move to 'crawl out'. Others, including Hine, Elizabeth, Charlotte, Hannah, Karen, Ruth and Katy all had relationships that were positive during times when they were severely depressed.

Christine and Kate both had partners who recognised the seriousness of their depression and encouraged them to get appropriate help, then supported them in many ways whilst they received that help. Marge had a long term partner who could see how difficult it was for Marge to continue working in her original career and "*convinced me to quit that job*".

Most of the stories in this section have been about the positive impact of friends and family on the women's lives and their ability to journey beyond depression. I will finish the section, however, by commenting on the stories of the three women who needed to end violent or emotionally abusive relationships before they were able to begin their journey. This was the situation for Naomi, Ruth and Fiona. In Fiona's case she could see the emotional poverty of the relationship, but experienced huge distress when her husband left. It took some time for her to begin to realise how bad the relationship had been. Naomi and Ruth were in violent and abusive marriages, which were extremely frightening and dangerous, and it was only once they had left those marriages that they were able, in Ruth's words to "*focus on really getting well*".

### ***Doing life differently in action and thought***

The pathways the women followed to begin their recovery were varied. These first steps included thinking differently and altering the way that one 'does' one's life. Many women made seemingly small changes which shifted them to a new path. Linda, for example, left a job in which she had been really unhappy and decided to become self-employed. She found herself unemployed for six months and struggling to cope emotionally. She developed a strategy which kept the depression somewhat at bay, and enabled her to cope better than she had imagined. She did this by "*working through lists and making myself do things*". At another stage she discovered a variety of forms of 'symptom relief' like "*a bar of chocolate, or a walk on the beach*". Other new

things Linda did in her life were swimming, getting out walking, listening to music and watching *“a very engaging film”*. She described many of these coping strategies as distractions, *“things I could get lost in”*.

Some of the women found *“body work”* or *“massage”* good ways to cope. Both of these were important for Elizabeth, and Kate found yoga *“made a big difference”* to her mood, although she had difficulty sustaining her involvement in this activity. Naomi found that one of the really healing things about living in New Zealand was soaking in the hot pools, and in summer swimming at the beaches. She described the hot pools as being *“almost foetal like, in a way”*. Christine’s preferred activity for a long time was walking. She did this a lot when her children were young, which was the time when her life was most disrupted by depression. She described her total involvement in walking:

*I walked and walked and walked miles,... I mean you can only play with a baby or a pre-schooler for so long ... I always walked a long, long way. I mean people used to – I used to look at the wheels on people’s prams and think “You’ve never taken this pram anywhere”. Ours were down to their bloody ... they were well worn. But crying never seemed so, never seemed so bad outside.*

Kate’s walking was less extreme, and she was inspired by her dog, who needed to be exercised daily. He gave her a reason to get out, which was particularly difficult during her worst times. It was best if she could combine walking with being in the bush, which she found healing in the same way that Naomi experienced the hot pools. Ruth included physical activity, especially aerobics, in a general move towards a *“healthy life style”* which focussed also on healthy eating.

Other changes were more within what might be called ‘cultural’ activities. Hine not only listened to music, but sang and created a band, both of which *“lifted her up”* and made her *“feel great”*. Karen was very involved in making music, but also in reading a *“whole range of books”* and she commented that she had *“always had books as friends and company... and as challenge”*. Chloe expressed her creativity through writing poetry; she did this at a time of major depression when she recalls *“I just couldn’t see my way out of it”*. She found that writing poetry enabled her to survive. It was part of her *“choice to stay alive”*.

These cultural activities are proactive, even though they were carried out in times of desperation. Other women talked about activities which were even more purely about survival, ways that they could take ‘time out’. Charlotte had recently discovered



the value of playing “*mindless computer games*”, but at her worst times in her early twenties she sewed and baked. She would sew for three days in a week, making all the family’s clothes, including her husband’s shirts. She explained that “*she used to use the sewing machine to come to terms with things*”. She recognised that these were things she could do “*without thinking too much*” and that they were what she needed in times of stress. She also gave herself permission to listen to the radio at night if she woke, using earphones so as not to disturb her husband. This strategy allows her to manage night-time waking without using it as a time to spiral into negative thinking or to worry.

Anne went to art school at the time when her life was most disrupted by depression. She made decisions based on her need to be by herself, and on her experience at high school of having been given a darkroom and studio by her mentor, so that she could have her own “*secret space*”.

*I chose photography because I could have my little dark room, personal darkroom with a closed door. So – much as I thought I’d have loved to have done painting and things – at that particular time what I needed was a space where nobody could come in and say “Oh, how are you getting on Anne? Oh, is this what you are doing at the moment? I couldn’t bear the idea of people watching me work and the only place where I could have that kind of privacy to expose myself and my work and decide what I was going to show was in a darkroom.*

Other women discovered ways of taking shorter time out. Hine, for example, found a respite home for women where there was “*lots of nurturing*” and “*good food, good attention, company*”. She recalled how wonderful it was that from being a single mother of three young children she could go to this Women’s Home and not “*get out of bed in the morning until you’d had your morning tea*” and someone brought that to her.

At different times women needed time out from different aspects of their lives. Ruth realised that a break of a few months from her intense, people-focussed work, was one of the things she needed to begin to move on. So she took that break and found “*that was great because I could sleep*”. The individual nature of these stories is highlighted, though, when beside Ruth’s story we hear from Chloe. She was “*incredibly anxious, and very depressed*” after the birth of her daughter. She realised that she had to quickly return to work since for her “*being a mother meant I had to be emotional, and I just didn’t want to go there. So, I raced back to work, and that was very helpful.*” Her mother-in-law cared for the baby, and Chloe whispered to me “*thank God, because I wasn’t able to do it*”. Chloe knew that for her at this time “*it was easier to be a [worker] than a mother*”.

Changes related to work and education were part of many of the women's narratives, and most did not link with 'time out'. At this early stage of their journey, many women could see education as a way of increasing their options in life. It was at times a choice of desperation. Fiona was on the benefit after her husband left. She had not been in paid employment for a long time, and knew she had to do something. She went back to University to complete a bachelor's degree, because it "*was the only thing I could think of doing*". This was enough to get her out of bed, or "*up off the floor*". Christine initially started tertiary study because after her first episode of depression she "*had to give up work*" and she felt that studying made her life easier. Karen was motivated to become involved in tertiary education soon after her first time of serious depression. She knew that she was "*hugely curious*" and that she "*loved learning*".

Kay also took on further education with enthusiasm, feeling that through this she was able to "*regain some of my former self*" and "*re-establish an identity outside of being a wife and mother*". She was aware that "*being under-challenged was dangerous in terms of acknowledging who I was*". Hine had never realised tertiary education was an option for her. She had taken on work in industrial sewing when her youngest child went to school, and found it was "*driving me bloody mad*". She was very fortunate to meet a counsellor who told her "*you're really bright, go to university*". This advice and her introduction to university and to her own intellectual ability were very significant at the beginning of her recovery.

Changes in paid employment were also made for a variety of reasons, and with differing levels of hope and enthusiasm. Naomi recognised that it was a major risk for her to become "*isolated*" and that this could let her "*start slipping into depression*" so every time she realised that was happening she did something to reduce the isolation, and one of these things was to get a job, any job. Chloe had been working in a job where she earned very little, but she had given up the work she was professionally trained for when she became very depressed, got involved with drinking too much and had a serious suicide attempt. As she was beginning to re-build her life she decided to re-train in her profession, and then return to work in a job where she could be paid better and begin to "*get a footing again*".

All the decisions that the women made, whether it be to return to education, to change paid work or to take time out, imply a change in how they were thinking about themselves and their lives. This change in thinking is often not mentioned specifically in the narratives. However, many of the women were aware of how their thinking

changed, and of the benefits they received from this. Kate made the power of this self-awareness very clear. She said:

*I remember one day having to go to the supermarket by myself and coming back and thinking "Wow! I did that!" You know, really basic things. That I just couldn't do myself. That whole thing about getting up and crying every day.*

At about the same time as this reflection Kate remembered realizing that she had to "take responsibility for my problems". One way she did this was to do some affirmations, "I believe in myself, my opinions and me". She started this because she had seen the idea in some of the many self-help books she had read. Kate realised that if she didn't find ways to "express myself" she would continue to be "fogged up" and would never move on. Hannah's affirmations were musical. She kept singing to herself "I am woman, I am invincible" which "really got me up". She began to feel stronger, and realised somehow that she "could cope". Kay worked with a reward system rather than verbal affirmations. She bought a box of chocolates and used them as rewards to herself in what she describes as a "very mechanistic" way, but one that worked by stopping the "negative cycle" of thinking. Later she rewarded herself by reading which reminded her that she was "capable of processing and assimilating". Christine was not explicit about what she did to help herself, except that she kept reminding herself "look after yourself, nurture yourself, be kind to yourself".

As the women developed self-awareness, they often realised the very personal nature of their distress, and how it related to their own particular life story. Naomi, for example, had a uniquely Jewish realisation at a time she remembers as the "start of integration".

*....so much grieving. I mean, you know I've just done so much grieving. It's like I sometimes think – how long can a person grieve?" ... One of the famous holocaust writers, I think she's a psychiatrist – she wrote something about, you know, it took a year for each person who died in the holocaust, or if you took a day even for each person, you know, you'd be grieving a life time. Something like that --- I remember that.... Yeah!*

Jane's self awareness was much more focussed within her own life and the historical times and linked significantly to her husband having left her, and to her difficulty in acknowledging her own anger. For a long time she "just cried" but "eventually" she learned to feel "angry" and made herself think "I feel so mad at him!" This realisation was "really energizing" for her, and allowed her to begin to move on. Isobel had

similar difficulty letting go of her need for her husband who had left. For a long time she followed him and his new partner, but made a significant break through when she decided not to contact him and not to let him contact her. She had realised that each time they had contact she would “*hope for the next hour or two*” and “*desperately want him back*”. She knew he would not return and that those thoughts stopped her moving on.

Some of the women recognised the seeds of resilience that were particular to them and these ‘seeds’ were nurtured and brought back to life as they started to crawl out of depression. Elizabeth was one who remembered her earlier skills. She reflected that she had “*always been someone who questioned things – why people do things, what is this about?*” She could see how this could help and began to explore things like “*yoga*” and “*natural therapies*”. Isobel looked back to a time before her marriage and realised that during the marriage she had lost her independence. She needed to reclaim it “*to regain my self-esteem and my decision-making*”. In doing so she began her journey out. Anne always valued reading and educating herself, and once she had been given the label ‘depression’ for her distress she was able to read about it and understand better what was happening to her.

Hannah, like Kate, noted in her story the time when she began to take responsibility for her thoughts and actions. She recalled how this awareness grew after her friend had interrupted her attempt to kill herself:

*I never went back, because I knew, I suppose self-preservation comes in here. You know, if you get right back there, you don't know if you're ever really going to get out the next time. So you don't go there.*

Hannah's statement makes it clear that, at least in retrospect, she realised that she was able to have some control over her mood. She could decide herself not to “*go there*”.

In the final section of this chapter I will consider this ‘self-determining’ quality that the women discovered to greater and lesser degrees as they crawled out of their worst places.

### ***Initiation of Responses***

This chapter has so far been organised around the kinds of responses the women made when their lives were seriously disrupted by depression. The person initiating the response has been mentioned where it was relevant. It is noticeable, however, that the

great majority of the moves are purposeful, which is in strong contrast to the ‘chaos’ of the stories presented in Chapter Six.

A way of highlighting this feature of the stage is to attend to the language that the women used to tell this part of their narrative. In the stories of journeying out the women increasingly use language which signified their belief in their own ability to make choices. Some examples follow, with the intentional action verbs underlined:

**Anne:** I wanted to take art .... So I went to my art teacher .... He [the art teacher] organised it so that I could do everything I wanted, so I did that.

**Charlotte:** I made an enquiry about the movement. ... I mulled it over and I did that, I took the baby group.. That was a turn round point. I started doing lots of things. I took up craft....

**Chloe:** I’m going to do this. I’m going to keep getting to the bottom of this. So I went to counselling.

**Elizabeth:** I rang this woman, and said “I’m really interested in learning...”

**Fiona:** I had to ring him up. And I had several quite overwhelming difficult conversations with him .... It was really quite torrid. I was trying to say something quite difficult.

**Hannah:** I worked very hard to get off that [medication]... I didn’t want to stay on that .... So I came off that.

**Hine:** what I really found unhelpful, but it ended up being quite good, because I ended up resisting it, was when people slotted me into a little box of being depressive...

**Isobel:** I just said “I don’t want to hear from you again...”

**Jane:** .... I pricked up my ears, and I said to myself, “What group?” .... and I thought “Well, hang on, .... I need to go to that”

**Karen:** I made a decision at that point not to have another psychotic break down.

**Kate:** I rang the Women’s Centre...

**Katy:** I’m bloody minded. I hate the thought of some artificial chemicals specifically telling me how I should feel ...

**Kay:** I grabbed a taxi and went to the Women’s Health Clinic ...

**Linda:** I took myself off overseas for six months ...

**Marge:** *I don't need to do things that are set up to make me feel bad about myself.*

**Naomi:** *I knew I had to get out.*

**Ruth:** *I thought, I've got to meet this guy [a recommended counsellor]*

I have quoted just one example from each of the eighteen women, from their stories about crawling out, and every quote is representative of much of the language they used. They were all able to talk in proactive, energised, determined ways about their actions, thoughts and decisions. These verbs in context are very different from the chaotic “and then, and then, and then” of the disrupted times. Not only are they indicators of action, but they are linked together in meaningful sequences by words like “so” and they have clear objects, like going to a place, meeting a person, deciding not to take medication or choosing to stop thinking badly of oneself.

Throughout these stories there are examples of the women taking, or not taking advice from professionals, friends or family. The advice is offered, but the women constantly talk about their responsibility in accepting, rejecting or resisting the offers. The first stories presented in this chapter are those which show least resistance and least agency; they are about ‘doing nothing’. A common factor in these more passive stories is that they occurred at times where the women had little power. They are gendered and ageist stories; the women were often unable to be pro-active because of their marginalised societal position as children, adolescents or traditionally submissive wives. Even women who had found more powerful positions in their world as young adults with work and freedom returned to less independence when they became mothers.

Relationships were key to women claiming or re-claiming power. They often emphasised the relationship with professionals. When they felt heard, and that their story was being listened to and valued by ‘experts’ in the medical or psychological world the women began to find ways to act for themselves. Contrary to the readily available belief that women who are depressed are powerless, these women talk about a determination to do what they believe will work for them. When they made false starts they found something else to try. The stories in this chapter demonstrate a growing awareness in the women of their right to feel better, to live a life that was less disrupted, to allow themselves to be nurtured sometimes. Their connections with others

are one of the aspects of their lives which allowed transformation, including growing conscious awareness of their own values and needs and their right to have at least some of these needs met. The women are beginning to choose to be ‘other’ in a way that is positive for them; they are finding ways to be ‘other than depressed’.

The next, and final chapter of findings (Chapter Ten), will focus on the narratives about recovery. The stories of how the women all managed to find a formula that worked for them.

## Chapter Ten: “Getting the Formula Right”

Ruth talks about the right formula for her:

I like to be in control of myself,  
the medication has had a place,  
but it really hasn't worked for me  
not in the way that I was lead to believe it would.  
There's no magic answer.  
It's got its place, but for me  
Those two experiences, Prothiadin and Aropax ,  
I don't want to entertain that again.  
But I would entertain medication or something  
whereby I understood it completely from the chemical point of view,  
and that I was being monitored.

In the past it's been exercise,  
just sort of getting out and doing things.  
And keeping myself busy,  
whereas now I see it as  
I'm doing things because I know why I'm doing them.  
So the awareness is very,  
I'm very aware of it.  
Very sensitive about it.

Exercise,  
to get up in the morning  
and to go for a strident walk,  
is the best way to start the day.  
Ah, sometimes its very hard.  
But I make myself do it.  
So it's mind.  
I insist on getting up,  
and within five minutes of leaving the house,  
I start getting up, up , up , up, -----  
Come back, have breakfast, fine!  
And the food.  
So its what I eat,  
and exercise  
and also sharing with a few very close intimate friends.

That is the formula - for me.  
And another part of it is  
exploring things more metaphysically maybe.



Ruth used the phrase “getting the formula right” and in the story just cited she explains what that meant for her. In these few words she mentions the range of different actions and ideas than can be part of that formula. She includes the relatively practical activities of having the right food, and regular exercise, the importance of relationships, and being able to share with friends, the possibility of medication being helpful, the significance of self-awareness and finally the ‘metaphysical’. Throughout this story she demonstrates how she has managed to take control of her own well-being. She also refers, however, when talking about medication, to the need at times to have a knowledgeable person to explain it to her so it could be meaningfully monitored. At another stage of her story she talks about the importance for her of finding the right counsellor – her Merlin – she calls him.

This chapter is about the combinations of different ‘things’ that worked for each woman. The ways that they managed to “get the formula right” as Ruth put it, and create or re-create a life with meaning beyond the ‘chaos’ of their worst times. In Chapter Nine I analysed the processes that the women went through to reach the stage where they could make choices that worked for them. The narratives suggest that none of them arrived easily at their right combination. I will present this chapter through each woman’s story of the formula she found worked for her.

The formulae that ‘worked’ were for some women relatively simple, but for most they were complex. Recovery is seldom complete, but is ‘under regular review’ as the women discover how best to continue to live a life without any major disruption from depression. In this chapter I consider each woman’s narrative, and present my re-telling of the significant elements involved. I organise these stories into three general groups, starting with those where the disruption took place in relatively well-defined periods of their life. The second group consists of the women who saw depression disrupting considerable periods of their lives, sometimes in a major way, and at other times in a less serious way. The third group includes all the women who consider that depression is still a part of their lives, but that it is no longer a serious disruption. I have chosen this organisational structure because there were patterns that emerged from the stories that suggested that the recovery stories were connected with these particular patterns of disruption. I will further expand on this issue in the final section of the thesis.



fourth stories are those of Katy and Kay. Both of these women had an initial period of depression related to the birth of a child, and each had a second disruption with a different cause. Hannah's first experience of depression was related to her responsibility for young children, but also to the break down of her marriage. Her second experience was directly connected to the failure of a business. The stories of Jane, Fiona and Isobel conclude this group, and all of them experienced depression following the ending of a marriage.

### **Charlotte – Re-discovering a 'family group'**

Charlotte's formula focussed around people. Immigration had separated her from friends and networks, then she had a baby, took time out from her career and moved to an unfamiliar and isolated suburb. The need to re-establish meaningful contact with people was paramount.

Charlotte talked about a "*turn around point*" which came through happenstance. A stranger knocked on her door when her life was so "*grey*" that she "*didn't feel alive*". The visitor was selling Girl Guide biscuits and this triggered Charlotte's memory of her involvement in guiding. She asked about local guides and became a volunteer helper, thus reconnecting with a meaningful time in her past. This "*was just enough*" and soon she "*started doing lots of other things*" most of which echoed past involvements. She fostered babies, started a play-group and did craft work. She was able to start "*looking outwards*" and once more had "*influence*" and "*structure*" in her life; concepts and words she used often in this part of her story. Her life had structure when she had a meaningful "*context*" and "*culture*" for her daily activities. Following the visit of the Girl Guider Charlotte demonstrated agency in directing her life towards meaningful activities, which for her seemed to involve community and giving.

In the previous twenty-five years most of Charlotte's family had migrated to New Zealand. She again had an extended family, on the opposite side of the world from the village of her childhood, but with the same comfort and familiarity. She talked of her family lovingly and in detail, emphasising its significance to her sense of well-being:

*And then at Christmas and my son's twenty-first there were.... twenty five of us. That sort of, you know....so people come, and they all bring a plate and all get round the table, and everyone's talking at once, and*

*my brother falls asleep and they put tinsel on his head and it's all that sort of extended family situation.*

Maintaining cultural continuity was important. Once a week Charlotte had her grown-up children home for dinner, and after dinner they played cards. The grandchildren stood behind the adults and learned to play five hundred just as she and her father had learned.

As Charlotte maintained her recovery she learned to manage issues that she once understood as symptoms of depression. She set up “worry” times, and she “*keeps myself busy*” often in career-related activity. Also she spoke of consciously re-framing problems, such as waking at night, as opportunities:

*I wake up and I think “Oh, I’m awake. Does it matter? No. It doesn’t matter. Because it doesn’t, really. Because I know that if I don’t sleep tonight, and I don’t sleep tomorrow night, then the next night, I am sure I can sleep well.” So, I keep a radio by the side of the bed. And there are some fantastic programmes on. At half past four. In fact this morning, I woke up at five to five, and thought “Hell. I’ve missed “Just a Minute”!!!*

The ‘right formula’ for Charlotte involved people, especially family and groups of women such as mothers, craft-workers and guiding leaders. She also found ways of being “*involved*” through her career, and incorporated meaningful and fun activities into previously ‘low’ parts of her life. Charlotte believed that living life with “*involvement and passion*” and maintaining “*engagement with people*” were the keys to avoiding depression again disrupting her life.

### **Christine: support from a “wonderful” psychiatrist and a “neat” husband**

Christine was guided towards her ‘right’ formula by a psychiatrist, whom she described in glowing terms, such as “*just fantastic*” and “*just marvellous*”. Initially Christine followed her suggestions because they had a good relationship and she wanted to please her. Christine felt unable to leave her new baby, but the psychiatrist suggested she take time for herself, even just 30 minutes a week. Later in the story, when Christine was unable to take control of her own life, the psychiatrist was very understanding but directive:

*I can’t remember what she does. She does a lot of talking, a lot of challenging your thoughts about why you think this way. That is, she is very woman focussed. She, I think now she only works with women. Umm, but she’s very woman focussed.*

The psychiatrist gave Christine support, and she was also supported by her husband throughout her worst times and through her recovery. *“There were a lot of hammerings but we’re a really tight group, we’re a really good team.”* She talked warmly of his place in her life:

*He’s grown me, he’s grown me. I’d be nothing. I can’t say that. I’d be much less a person without his support. And umm, and, you know, he’s, he’s just been there. He’s just such a neat guy.*

On a different level Christine found it was really important that she develop an understanding of how society has shaped women and their roles. She started this discovery with the guidance of her psychiatrist, then learned more through formal and informal education. She talked of this growing awareness as significant in her recovery: *“I really now see the way it was - the socialization of women, and how it works to control us”*. This understanding enabled Christine to be *“kinder”* to herself and not to feel so guilty. This was especially important when she became depressed following her involvement in a road accident where a person was killed. Christine was in no way at fault, but she took a year to return from a *“zombie like state”*, which she named depression. Another element of self care has been her decision to do tertiary study extra-murally over a number of years. This has been *“stressful”* and expensive but has also given her a *“huge sense of empowerment”*.

Medication was another part of the formula that worked for Christine. At her worst times she took Prozac, and found that *“that was good, that really suited”*. She maintained her depression free life by referring back to her psychiatrist when she knew she was at risk, but mostly by keeping a healthy, balanced life. She worked to maintain good relationships with her husband and her children. She studied, and she ate healthy food. She also commented on her relationship with her environment;

*I’m a person who needs the outdoors. I, I very much need to do stuff outside. I need to walk and think and look and, and I need time out to, I don’t necessarily need to do it alone, but, I find city life very stressful, and I need to walk and smell and look and touch, and I really need grounding with the earth and the bush and the sea. That is, possibly, one of my greatest things.*

### **Katy: “My God I’m going to live my life. I’m not going to sit here rusting away!”**

Katy gave unexpected meanings to some significant events in her narrative. When I wrote about resilience I explained how she told of loneliness and bullying at boarding school as opportunities to learn how to enjoy being on her own. As an adult, her son

died in a traffic accident, and she was adamant that she had truly accepted this, and it was not a reason for depression.

Katy experienced two significant episodes of depression. The first followed the birth of her second child, who had difficulty breast feeding. Katy and her small family had a low income and lived in a new suburb. She was feeling low and saw a doctor:

*I went down to see the doctor and bless his dear heart I'll never ever forget him for this. He said "I can't deal with this here and now – I'll come and see you this afternoon. He came and he spent 2 hours with me and I don't think he ever charged me for that visit and we just talked and he just said to me, "Katy, I can put you on pills" he said. "I could send you to a mental hospital for a time". I said "I won't go". He said "I really feel all that you need is to learn to drive. Then you can perhaps take your husband to work and have the car for the rest of the day."*

Katy and her husband needed to “scrimp and save and do without all sorts of things” for driving lessons and a licence. They did this, and she did not experience depression again for over twenty years.

Katy's second encounter with depression came after she organised her daughter's wedding. Her recovery was very quick, and she attributed it entirely to homeopathy:

*He [the homeopath] went through the whole damn lot. And that in itself is cathartic. At the end of it he said OK. Gave it to me. It was a pill actually. Stick it under your tongue. Stay off coffee for a good fortnight, and we chatted on for a little while. And within half an hour I started thinking. I'm better. And I thought – oh no – you know, I'm a believer in homeopathy, but even so – keep an open mind. You've just talked about yourself for two hours so of course you're going to be feeling better. So, I just said to him "I do feel better, but I'll hold my judgement on it."*

Katy found that it really had worked. From then on she felt “normal”, and “joy” was back in her life. She kept a diary after visiting the homeopath, and noted she could “clean her teeth” and “enjoy” a bath again. She described herself as again being “the sort of woman who wakes up in the morning thinking, whoopee, here's another day”.

Along with Katy's enthusiasm for life and for the hard-work on her small holding, she has been sustained by her husband whom she described as “a lovely man” and by her faith as “a devout Catholic, practising Catholic”.

Katy knew she could still be vulnerable to depression:

*I won't say I've never had depression since, I do. But, I think I've figured out why. And I also have developed mechanisms for coping.*

*The main one being an awareness. To know that when I wake up in the morning, or at some stage during the day I start feeling “This is just too much, I can’t cope” OK. Just you don’t have to do anything about it immediately. But just be aware that its there. And if you’re still feeling like that tomorrow, do something. I take St John’s Wort. If I take it at that point it never goes any further.*

**Kay: You need many avenues, but “other women” were the key.**

Kay’s life was disrupted by depression after the birth of her first child, and again after her husband had a serious traffic accident leaving him with brain damage. The formula that worked for her recovery involved her recognising her own worth as an intelligent woman. She furthered her education, developed a meaningful career and ended her unsatisfactory marriage. Her search for knowledge was fundamentally about “*trying to make sense of my life*”.

Kay was pro-active in her quest for recovery, and she found that other women were her best resource. After the post-natal depression she realised that she did not know other young mothers, so she went looking for them when she was out walking. She then started a “*support group*” in a “*little local hall*”. It was amongst other women that she found the “*empathy*” she needed, rather than the “*sympathy*” that she had experienced from some friends and family. The company of women enabled her to move from “*the faulty thinking of a depressed person*”. She also had recognition from professional women, and was invited to speak about post-natal depression at a seminar day. Kay reminded me that her pro-activeness did not just happen:

*It was born out of a sense of utter desperation and desolation. I’ve got to do something. I’ve been to the doctor, I’m taking medication. You know, I’m having a rest when the baby’s asleep. I guess what I was looking for was the one magic answer that would lift my spirits.*

At the time of the birth of their second child, her husband offered very practical support to prevent a return of depression. He hired someone to help out in the home, and Kay found the woman’s company more important than her practical help:

*It was someone to talk to during the day. It was somebody that was equally interested in young children. And we had great fun. And it just completely reinforced for me that women need other women. And a variety of women.*

When Kay again experienced depression she sought counselling, and she came to a clear decision that she needed to leave her marriage. She wanted to free herself and her daughters from the constant presence of her husband and his negativity,

unpredictableness and bad moods. She recognised the need to “*establish*” her own “*self-esteem*”, and that she was “*entitled to ask for things and demand them even*”. Through the journal she was encouraged to keep, she gained awareness of the “*negative spiral*” of thinking that she could get into. She was also able to find a “*circuit breaker*” which for her often involved countering the negative thoughts by entering three balancing “*positive thoughts*” in her journal.

Education and recognition of her intellect were other significant factors in Kay’s journey beyond depression. She returned to university, completed some qualifications and continued to work on others. She learned that she was respected for her abilities in her own career and this reinforced her own self-esteem and her sense of entitlement. She no longer felt that she was “*mother as road-kill*”.

**Hannah: “All that I have walked is for a reason, and to benefit mankind.”**

Hannah had two major episodes of depression. Neither medication nor counselling were helpful in her recovery, instead she drew on her passion for “*something of the arts*”. She belonged to a painting group when she was interviewed, but decades earlier, drama had helped. Her involvement in amateur dramatics was valuable in at least two ways. Hannah saw herself as a very “*emotional*” person, and acting helped her to “*get it out*” in a safe way. Also she met her second husband through drama, and he has been a significant support to her ever since.

Hannah talked of caring more about her children than the arts. She was a single parent, having left her husband:

*I was offered all sorts of parts through the amateur dramatic society. Because I’d done quite well. But I rejected that, because I knew that you can’t be involved in something like that on a hobby basis. It’s not one night a week. And I knew that as far as my children were concerned, that I had to show them that I was there, and support, which I did do.*

Hannah also made paid work a priority, so that she could bring in a reasonable income. It was these positive moves to support her family that enabled her to stay well. She explained “*I knew I was fragile, but I also knew that I could cope. That it wasn’t impossible.*”

Many years later, the second time her life was disrupted by depression, Hannah was in a supportive and loving marriage. Re-birthing was right for her at that time: “*It*



*made a huge difference. I felt totally cleansed, and worked through lots of issues through that particular form of therapy. I found it excellent for me."*

Ever since her first experience with depression, Hannah had been asking questions such as *"why do bad things happen? Why did this happen to me?"* In seeking answers she had become a spiritualist, and believed that experiences were there to *"strengthen"* her. She incorporated spirituality into all aspects of her life, and used prayer and meditation. Looking back she recognised that; *"The spiritual aspect is what has taken me through, it really has."*

Hannah talked of developing patience and acceptance. She believed that age is an advantage, and helps the development of wisdom. She had a growing awareness that she would try not to judge others, but to *"value people"* because she could never *"walk in their moccasins"*. Her advice to people who experience depression was:

*... walk the moments, and you will find that those moments will turn to minutes and the minutes will turn to hours, and the hours will turn to days, and slowly you will find... and you'll come through it, because, I think when you're in those sorts of depressions, all this sort of thing about "pull yourself together" and "look out there it's a beautiful day" --- that doesn't help you.*

Hannah described herself as someone who would *"put her back to the wall and fight"*, and was determined not to let depression disrupt her life. To prevent this happening she continued to pray, to savour the natural world, to work on maintaining good personal relationships and to foster her own creativity.

### **Jane: No longer bitter, but a better person with the support of friends, a 'separation' group and many, many books.**

Depression disrupted Jane's life after she separated from her husband. Her recovery formula contained many different elements. The first was a therapy group which she discovered through happenstance. She said *"I was crying my eyes out, feeling absolutely desperate"*. She saw a woman on TV talking about a group for separated women, found out about it and went. She learned from the women in the group in an unexpected way. Jane had earlier been advised by an older woman not to get bitter. This advice was reinforced by her realisation that she did not want to be *"stuck in a bitter, angry, depressed place"* as were three of the women in the group. Jane initially recognised herself in these women, but wanted to move to the freedom and autonomy of three other women in the group who had *"let go of the relationship"*, were *"making good decisions"* and had a *"spark of life"*.

Jane also read a lot of self-help books, recalling that every time she had an angry phone call with her husband she would “*go out and buy a self-help book*”. These reinforced her need to grow her “*self-esteem*” and:

*... stop your whinging, stop your moaning .... I'd done everything in my power to get us, for our marriage to work. And now I was going to do everything in my power to get him out of my mind and get on with my life.*

Jane had four close friends who supported her throughout her recovery, by “*listening*”. One of them rang her “*every Friday night for nine months*”. She stressed the mutual nature of these valuable friendships, and told me how she was able to help many of these friends at later times when they were in crisis.

As she recovered Jane stopped living in a “*detached*” way with a focus on “*pleasing people*”. She became “*more real*” and more “*in touch with*” her “*feelings*”. One book she especially valued was about spiritual emergency and personal transformation (Grof & Grof, 1989). The same book was referred to by five other women in this study. Jane learned from it that “*successful living is the transcendence of loss*”.

Jane’s formula involved some very concrete actions as well as connections with friends, and growing self-awareness and self-worth. She changed her career and trained as a counsellor. She fund-raised for a school trip her daughter was making to Europe, and was able to accompany them free of charge. She accepted this because of her developing sense of entitlement to some good things in life. Another significant activity for Jane was that she learned to swim. Initially she would “*swim up and down that pool crying my heart out, in the water.*” Later she began doing sea swims; “*things I'd never done before*”. Swimming not only raised her endorphins but she “*felt very good about me. .... It was a whole new thing*”.

Depression is no longer part of Jane’s life. She explained that she had “*a major episode which I've come through and I'm out of. I think I'm one of the 50% that don't relapse*”. One way she measured her recovery was that at the worst times it took three hours to do her supermarket shopping but when she had recovered she was “*back to 50 minutes again*”.

## **Fiona: Re-inventing herself as solo parent, and motor-cycling woman**

Fiona talked of her life as still at times seriously disrupted by depression. However, as I listened I realised how far she had come from her worst times *“curled in a foetal position under the floor”*. She was still trying to understand why her husband ended their marriage. She explained; *“To this day I’ve never had a really good talk to him. To this day I still really don’t know what’s eating him. There’s still something wrong.”* This not knowing, and its consequences for her mood, continued to disrupt her life. She had, however, found many things that assisted her recovery. Antidepressant medication helped, although she was ambivalent about it and did not like the side effects.

The major feature of her ‘right formula’ was represented by her passion for motor-cycle riding. She talked of her brothers and father being competitive motor-cyclists. A male friend from her past became a great encourager involved in a major *“turning-point”* in her life:

*one day... J said to me “Tell me what you would really like to be now” and I said “I’d like to go back to being the girl I used to be”. And he said “Well what did you do when you were a girl?” And I said “Ooh....” I told him I rode motorbikes. “I rode my brothers’ motorbikes.”*

Fiona explained that her husband had hated motor-bikes so she never mentioned them.

J challenged her to try his 250cc bike.

*I said “that’s only a little motorbike, I can ride that” and he said “Oh Yeah!” I put on his helmet, I put on his gloves, I got on ...and I rode it all the way down the road, turned around and rode it all the way back again, and beeped the horn, and changed the gears, and pulled up and stalled it right in front of him. And he said “Good grief” I didn’t know you could do that. ... Why don’t you ride your motor-bike?” and I said “Well I’ve never given myself space to do that.”*

Fiona bought her own motorbike and joined a women’s motor-cycle club. She began to build a life of meaning and fun, and found a place to be herself. She came to value women’s company and to like herself.

*It is old women, young women, fat women, thin women, rich women, poor women, clever women and stupid women. There are.... there’s the smokers and the drinkers and there’s the health addicts. And there’s just every kind of women. There’s lesbians who are very well adjusted. And there’s lesbians who are not. And there’s the tattooed ones, and the pierced ones, and there’s the very ordinary middle-class ones. And I just took my place. It was just fantastic.*

Fiona talked with joy and enthusiasm of how “*gob-smacked*” her ex-husband and in-laws were about her motor-cycling, and even more so at how she had managed to “*re-invent myself*”. She did not need to re-invent her role as mother and home-maker. She was proud of “*running a really warm home*” and of knowing her teenage children are “*thriving*”. She talked of herself as a work in progress; “*I’m moving on in my own wobbly way*”. She had lost a lot of “*respectable middle class friends*” who had come to see her as “*a divorced woman who has gone crazy and who rides a motor-bike*”, and is “*quite disreputable*”. This loss had been more than compensated for by the companionship of her motor-biking mates, who “*call a spade a spade*”.

### **Isobel: “Hey! I’m me, and I really like me!”**

Isobel discovered her husband was having an affair and depression quickly followed. Her recovery took place over more than a year, and was facilitated by the support of very close friends and a wonderful GP. In these human relationships she was valued as a person which enabled her to develop a sense of her own worth as a woman. In doing so she could break away from her overwhelming need to take revenge on her ex-husband and his new wife.

Progress came through determination and the journey was never easy for Isobel. She was in tears as she recalled a significant time in the growth of her independence:

*And that was a real turning point and I’ll never forget that. Actually saying to him. And I got off the phone and I thought did I really say that? Did I really say that I don’t want to hear from you again. And that was really a turning point so....*

Isobel kept busy with embroidery and with friends, as well as bringing up her three children. She also returned to her career. She recalls that “*after about six months even though I still missed him desperately I knew I was okay and I was focusing on the kids*”. Friends “*constantly rang*” her “*without appearing to check up*”. What Isobel experienced was that “*they really cared*”. Friendships and her GP’s support made her realise “*I’ve got to get on with this*”.

The piano is a significant ‘character’ throughout Isobel’s narrative, and it serves her in many ways:

*When I get angry at the kids and I know that I can get really angry - that I’d want to say things that I shouldn’t say, I’ll actually go sit at the piano, play something really loud until I finally calm down and I’ll be playing something really quite soothing at the end. And it’s just, I mean if I didn’t have my piano I’d only be half me...*

At one time Isobel was afraid to return to feeling suicidal and unable to even get out of bed and dress herself. That fear helped her to do what she had to do:

Isobel became independent in spite of her fear of giving up her dream of security based on the traditional nuclear family. Her friends have told her she is “*a different person now*”. She recalled that she “*didn’t know how to make decisions*” but she came to love not having to answer to anyone; “*I make decisions now. If they’re wrong well .... I don’t answer to anybody.*” Her determination shone through her entire narrative: “*I’m a much stronger person now. I’m not scared to try new things. I used to be terrified of trying new things. I mean .... that’s not true, I am scared of trying new things, but I will do it.*”

Five women's stories are included in this group; all of them had their lives disrupted by depression to a greater or lesser extent over a long period. Anne and Chloe both experienced ongoing childhood trauma and Kate suffered a loss in her early teens. Marge's depression related to her career, and Linda's to her body.

**Key:**

**Figure Six:** Historical context within which the women's lives were disrupted by depression. Group Two: Depression causing ongoing disruption over a long period, both serious and less serious.

As with the first group, Figure Six presents the five women in alphabetical order, however I will start by presenting Linda's story, follow up with Marge and Kate, and conclude with Chloe and Anne.

Figure Six shows that for all these women depression disrupted their lives to a greater or lesser degree for most of their adult lives. For many this disruption started during their teenage years. The women often took some time to discover a formula that worked for them to reduce the impact of depression on their lives. Both Marge and Anne continue to work hard to keep depression at bay.

**Linda: "if a person presents with some sort of depressive illness, there's a reason"**

Linda's story has many elements that are unique in this study. Her formula for 'getting it right' was in many ways quite simple. Although she had been anxious for a lot of her life, she became increasingly depressed during her late twenties after she married and discovered that sexual intercourse was painful. By the time she told me her story Linda knew that her life had been seriously disrupted by depression, but that this chaos had been caused by a faulty diagnosis. Much of Linda's story concerns her attempts to find the right formula. She had Christian beliefs and values which meant she did not have sex before her marriage. She went to her GP to discuss the extreme pain of intercourse, but was not given a physical examination. Instead she was referred to a therapist to be treated for anxiety. Linda paid for private psychotherapy for more than two years, the problem did not change and she became increasingly depressed.

At the worst time both Linda and her husband were on antidepressant medication and she felt *"it was almost impossible to believe there was any way out"*. At this time, following the advice of a close friend, Linda went rather reluctantly and in spite of her *"cynicism"* to a different therapist. This person was the key to the formula coming right. She assured Linda that *"you don't have to keep going along to someone, if you are coming away feeling always, that it's just not going anywhere"*. She insisted Linda see a gynaecologist before having any more therapy. At first Linda could not believe her GP had been wrong. But she did follow the advice:

*...it took several months for me to get to see this person, who was a very, very good person. And when I did I went in and she examined me, and after 10 minutes she said, well I know exactly what the problem is. It's this, and she gave me all these handouts. Plonked them on the desk, and said "You'll need to have some surgery for this, because it won't go away" and, ah, I was just shell-shocked, I was*

*absolutely, I was absolutely in, I was just all in outer space after -- I remember going in to write the cheque for the consultation and thinking, "I just don't believe this"-- "How could I let this go on for so long" "How could I have felt so stupid?" And, umm, and so inadequate, the whole marriage was such a terrible time, and felt so-- .so much my fault, and my own responsibility.*

Once she had this diagnosis Linda was able to have the appropriate surgery and to finally have a good sexual relationship with her husband without pain. When she came for the interview she was 8 months pregnant with their first child, a joy that she would never have believed possible. She talked of the diagnosis as *"the most re-assuring experience of my entire life. To be told, that I had something wrong with me."* She knew she was *"not a head-case"*. From the time she learned of the physical problem Linda said *".... from about that point on I stopped feeling depressed. I don't remember having anything like the sort of black days I had."*

Linda maintained her well being through physical activity, especially tramping where she loved *"climbing up very high.-- in the clear air."* It helped her to realise *"there's a big world out here, and I'm just a little person in it. And this is really amazing."*

### **Marge: "...it had to do with work – I need to let my mind wander and potter..."**

The major element in Marge's formula was giving up the paid work for which she was highly qualified, and could be employed and paid very well in many countries. This significant life style change took place with the love and support of the woman who was her long-term partner. Counselling and medication were also helpful.

Marge tried many kinds of counselling which made little difference, but finally discovered psychosynthesis which she found *"extremely helpful and a huge part of my recovery"*. She explained that *"the psychosynthesis thing"* is that *"the answers are inside of you .... and that's quite a useful thing to say to somebody"*. For her this meant that she could try *"various ways"* to build up to recovery, and not expect there to be simple answers. The therapy was *"intense"* and *"really gets into your soul"*. It helped her to *"really get to the bottom of what it was that was going on"*. Marge came to understand that she had *"performance anxiety"* as well as feelings of *"not being good enough"*, and a *"fear of criticism"*. Counselling enabled her to implement significant changes in her life, including deciding to finally quit her profession. She celebrated this

decision by burning all the books and notes she had accumulated for more than a decade.

Marge replaced her full-time, professional career with part-time work that was more person-centred, working with children with special needs. Whilst it was not as financially rewarding as her abandoned career it suited Marge well. She had worked with children before in a voluntary capacity and considered herself a “*natural*” with young children. This new work had different rewards, and Marge said it helped her “*feel like I was worth something to society. ‘Cause, you know, I knew I was worth something to my partner. But I didn’t think I was worth anything to society.*”

Marge did not like taking medication, and “*had a really hard time with side effects*”, but she “*immediately felt better*”, and was clear that she needed to continue. She explained that “*even after making all those changes in my life*” when she stopped taking medication “*I just felt myself going down right away*”.

Marge also found she needed to “*protect herself*” from the harsh realities of the world:

*Sometimes I just had to protect myself, when, when I’m in that state I feel like the world is an incredibly horrible place to be in. And the violence and the people being so cruel to each other. People being cruel to animals. I mean it bothers me all the time. But when I, during that recovery period, you know, sometimes I couldn’t watch the news.*

As Marge maintained her new life with her partner, and her more rewarding, less stressful work, she was kinder to herself. She stayed in bed all day when she needed to, enjoyed reading for relaxation, sang, enjoyed the company of her cat and altogether she was “*arranging things so that*” she was “*not feeling bad about*” herself. She managed to remove many of the “*shoulds*” from her life, “*with incredible support from [her partner]*”. When she reflected back on her journey Marge said:

*I just hate working full time. You know, I’m just, I’m a person who needs, who just needs time to kind of let my mind wander and potter around the house and take, and have sleeps..... Following my heart. I really had to learn how to follow my heart rather than following my head..... And kind of allowing some of my passions to kind of be recognised, I suppose. Like I do have a passion for animals ....*

### **Kate: Learning to live a life full of colour.**

Depression came into Kate’s life in her early teens, when her parents separated. It went unnoticed and undiagnosed until her late twenties. It was complicated by agoraphobia, and for many years Kate “*masked*” it with partying and drug taking. Recovery began



when Kate consulted a naturopath who told her *“You need to give yourself permission to enjoy yourself”*. This let Kate know things didn’t need to *“stay the same”* and that she could *“actually do things to make a difference”*.

Kate was interested in massage and healing, but had not used them herself. Then something happened:

*One day a woman turned up unexpectedly, and said “I have just been for this healing down the road. They’re only .... they’re in your road. And it was just amazing. They’re energy workers they work on your aura. Kate, it is so up your street.”*

Whilst having many sessions with the healer, Kate said they did *“shit loads of work”*. Kate *“trusted”* her and there was this *“enormous outpouring”* which was *“far more than with the counsellor or the psychotherapist”*. They did *“energy work”* and *“body work”* and *“bach flowers”*. It was physical, emotional and spiritual, and she said it was *“all about love, the more you radiate love the more you get in”*.

Kate worked on her recovery through various involvements and activities. Some she knew she would have dismissed as *“airy-fairy, flakey and hippy”* but they have transformed her life. She took charge of her own life. Before she was *“never really paddling”* but she became proactive. She was helped by a homeopath, she did yoga, she became a *“white witch”*, was involved in goddess worship and learned belly-dancing. Through these interests she met lots of *“empowering women”* and was no longer without friends and dependent for company solely on her partner.

Kate became able to relate differently to people, not to avoid them, but to join with them. Her father visited and she could walk with him and her dog exploring local parks for the first time. She could see the great importance of her relationship with her partner who had supported her throughout. She told me *“I credit him with a huge amount of my healing, because he would really challenge what was coming out of my mouth, and he is quite a challenging person, but he never really withdrew”*.

When she *“looked back”* Kate could *“not really recognise myself”*. She could say *“a bad day now is maybe a couple of hours worth of feeling really awful”*. She learned to ask herself *“What is this really about?”* She reminded herself *“This is not actually depression, or, it is, but the depression is about something.... you have created this, and you can get rid of it.”* Kate treated her depression or *“bad mood”* as *“a cloud that comes down to obscure the real problem”*.

Kate's narrative was full of colour. She talked of her dress sense, and how she always used to wear black. As she recovered she was able to *"look at a red dress and a black dress, and think – ooo – I'll have the red one"*. She felt choice of colour *"reflects your state of mind"* and recalled wistfully her teenage *"best friend"* who *"was always like an explosion in a paint factory"*, while Kate dressed in black. I interviewed Kate in her own home, which was painted in a multitude of bright colours, and she talked about the joy she had had creating this environment. The colours on the walls matched the colour in her life, as did the clothes she now chose to wear.

### **Chloe – finding the wise woman, the good mother and the nurturer in herself.**

Chloe travelled a long winding route to recovery with many false turns. Key elements were spiritual meaning-making, and developing sufficient self-worth to enter into a mutually respectful marriage and become a parent. Homeopathy, astrology and a deep, spiritual form of therapy were also important. Her discovery of astrology was a *"door cracking open"* amongst the chaos. She remembered *"it was like, wow, my God. I knew it was me. It was very deep, kind of spiritual almost."*

When Chloe met the man who became her husband she realised for the first time she was attracted to someone who was not her *"father"*. It was a new kind of intimate relationship for her, one with love and hope:

*I felt loved .... he would bring home flowers, and he was, ....he is a very caring , kind man, and he endured a lot of crap. He really did... I used to say to him, "Why do you stay with me?" and he would say "It's because I see beyond that all to what I care about. So he could see --- you know the grain of hope."*

Through therapy Chloe came to what she described as a better, more complex understanding of her relationship with her parents. She learned which issues were her mother's problems not hers, a recognition that was *"probably the most potent thing he [the therapist] ever said to me"*. She spoke of her response in a whisper and with great wonder and awe: *".... it was such a relief. It was like "Oh God, it's not just me. It's not my fault. I'm not, I didn't, I'm not an evil person."*

Counselling helped Chloe, both as a client and as she re-trained to become a counsellor herself. The process was a *"cycle of discovery"* and very *"tough"* because she had to *"deal with myself"*, with the *"trauma of childhood"* and *"the terror"*. Homeopathic medicine had resulted in immediate improvement which then enabled her

to undertake therapy. Alongside the personal integration and spiritual meaning-making, Chloe also found ways to become free from her addictions to food, alcohol and cigarettes. Her new career in counselling led to her feeling *“I knew this was exactly what I was meant to be doing”*.

She had written poetry at many stages of her journey, and painted very powerful word pictures. One of these concerned her life no longer clouded by depression:

*.... Sometimes, in amongst all that, I remember sitting in the car one day with my husband, and I just had a moment of bliss. And it was just a moment, and I thought, “My God, that’s what people talk about. That’s what it is. I was sitting.... we were happy, we were off somewhere and the kids were in the back, and, and I just had that moment. Of bliss.*

The experience of “bliss” was spiritual:

*Because the bliss, I thought, is this the bliss? I know the bliss, this is it. This is what it means to be connected with the divine, this is it. I’ve seen it, I know it. And so, yeah, I had a hope.*

Chloe maintained the possibility of bliss in her life through sustaining her marriage and family, continuing with her counselling career, making an ongoing commitment to her own spiritual life, and a healthy, though distant relationship with her family of origin. She summarised her progress saying: *“I’ve found the wise woman in me, and the good mother, you know the nurturer.”*

## **Anne – Emerging from the dark**

Anne was a photographer and said:

*...the sort of work I did.... was naturally portraiture and very grainy parts of bodies and things and all faces merging out of blackness. I didn’t realize it at the time but it’s quite a strong statement about where I was at and this attempt to emerge from the dark.*

The two most significant elements in Anne’s formula were Jungian therapy and astrology. Her interest in astrology was awakened when she was a teenager. She was not living in the chaos of her family but in the home of one of her significant mentors. From this relative security she discovered astrology. Her growing understanding of this *“meaning-making map”* was at first *“soothing”* and then enabled her to be *“fore-warned”* and thus *“fore-armed”* for any *“hit”* before it came.

The second major element in Anne’s formula was long-term work with a therapist:

*...his voice felt safe and after first meeting I felt safe and that was the beginning of that seven years of work.. And really that work really did have to entail going right back through all of that right through a real restructuring process. Hell but there were a couple of times when there was an option for medication but I was already so impassioned about psychology I knew that this was my big chance to live and I wasn't going to take the route of medication because I didn't want to have to revisit all this later.*

Both astrology and Jungian therapy remained significant features in Anne's life as she maintained the meaningful life she had been creating over at least two decades.

Anne's journey had been slow, and had involved challenging, concentrated and deliberate work. Her children had provided her with the motivation to commit to this work, and friends, colleagues and family members had all at times supported the journey. People had provided an essential stability from which she had been able to focus on her recovery. The journey largely involved her own process, and only in therapy did she begin to experience "*looking to somebody*", taking notice of another person in addition to her more familiar process of "*looking to myth and other systems of meaning-making*". The inter-personal was never enough for her; "*In fact nobody could pull me out of that just by turning up in my life and having an emotional effect on me.*"

Anne's story of the serious disruption of her life involves "*anomie*"; her "*terror*" of being "*disconnected*". It is perhaps not surprising, then, that she sought a way to move beyond the chaos of her experience to structure and some kind of universal meaning. Anne's recovery focussed on the transpersonal, but she acknowledged that astrological meaning-making and her intrapersonal work in therapy were enabled by significant interpersonal relationships with mentors, therapists and siblings. The well-being of her children was an important motivating factor.

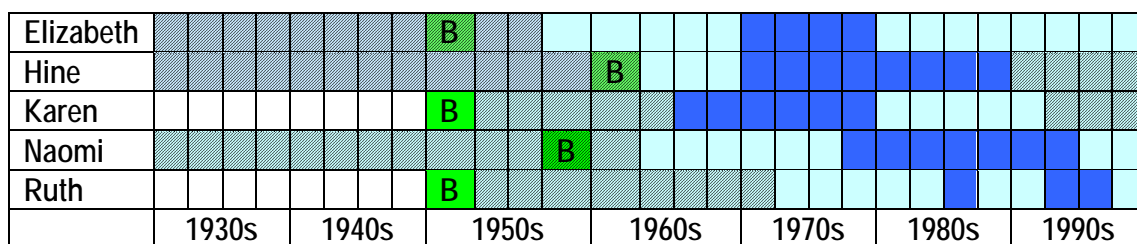
Anne knew her recovery was on-going, and at times experienced "*sadness*" but she was "*happy to know that emotion rather than getting caught up in that dark void*". She was able to review her life so far;

*You know, having said that, it was hell -- you know I am so lucky....my life has had so many opportunities in it that .... having said all of that I wouldn't've taken anything out of there except for the hell part. I think I am luckier than most in terms of vibrance of tapestry.*

Anne's formula centred on her search within herself and the universe for a life with meaning and without the chaos of her childhood and adolescence.

***Group Three: Depression as a constant presence in life.***

The remaining five women consider that depression has always been a part of their life, but that they have found ways to control its impact. The historical context of their lives is shown in Figure Seven. Hine and Naomi understood depression as a part of their cultural heritage. Karen's narrative was closely connected throughout to her experience of a disabling condition in her physical body. Elizabeth and Ruth both talked of depression as always being a part of life. Elizabeth talked of factors passed down through her family. Ruth's understanding was more meta-physical, and concerned with the state of the world she and we live in, particularly the situation for women.



## Key

<b>B</b>	Birth of woman	Potential for depression	Depression a part of life	Life seriously disrupted by depression
----------	----------------	--------------------------	---------------------------	----------------------------------------

**Figure Seven:** Historical context within which the women's lives were disrupted by depression. Group Three: Women who have depression as a constant presence in their lives.

These five women have discovered formulae for ‘getting it right’ which allow them to control the impact of depression on their lives. I will first present Karen’s narrative, then those of Elizabeth and Ruth, and finally the stories of how Hine and Naomi have found ways to live meaningful lives that are no longer seriously disrupted by depression.

**Karen: “Self-knowledge has been such an important key”.**

Karen, who had lived for 50 years with an increasingly disabling condition, realised in her teens that she was depressed. Before she was twenty she had been hospitalised a number of times, had experienced helpful and unhelpful therapy, taken various antidepressant medications and had a number of ECT treatments. She reflected back on what had worked for her, after many false starts:

*I think we just had to go back, and be – in a kind of archaeological way, get right back, and back, and back, and back, and deal with each*

*of the key either traumatic events of my physical body really, were the main ones--and it just had to be done -- So, I guess there were sort of layers of things going on in a way. Like I was reading heaps, and I was going off to -- kind of courses down at an ecumenical place, and I was seeing a therapist once a fortnight, and I was working away with my active imagination...*

This slow process took years, and whilst Jungian therapy was a significant feature of this “*reparative work*” and she produced “*folders of art and writing*”, Karen also benefited from counselling and trained as a therapist.

Karen realised that she had at a sub-conscious level decided that “*it wasn’t safe to succeed*”. As she became aware of such unhelpful beliefs she worked to change them, and to live her life differently. She continued to increase her “*self-knowledge*” through therapy, counselling, reading, formal education and astrology.

Karen’s physically disabling condition is a factor which was interwoven throughout her narrative. It took her many years to “*own*” that she “*had a physical disability*” and that this was linked to her experiences of depression. An important turning point related to her body and her self-directed recovery came in her late twenties:

*....the crunch came when they said to me “If you come in here one more time, we’re going to put you on lithium”, and I don’t hold that against them at all. But I do know enough about lithium to think , “No, I’m going to be totally tied into the hospital system...my kidney’s vulnerable ... I’ve only got one, and I’m going to have to be monitored so carefully its going to be a huge, huge drag. And I’d do anything not to have to do that. And I made a decision at that point. And it was semi-conscious. I will do anything not to have another psychotic break down”.*

From that point on Karen never went back into a psychiatric unit. She learned better management and self-care skills, including taking herself to bed when she needed it. She also realised that the issue of disability involved social justice and that disability and oppression were connected in our society. She described this as “*an amazing change of perception*” and this awareness enabled her to develop a proactive approach to her life with disability.

“*Community*”, which often involved some form of “*spirituality*”, was another key to recovery. Within communities came relationships and Karen reflected “*I seem to be able to attract some good friends*”. Her extended family were “*clannish*” and within this ‘whanau’ she found that music and humour were encouraged, and that she

experienced “a lot of caring”. Music held a very special place for Karen, she explained that “some people have the sea as their love, but I think music was my mother”. Her husband was significant throughout her adult life, and he continued to be “number one” in her life. He was in the background of much of her narrative as a support and constancy.

### **Elizabeth: Discovering really deep down a sense of soul and spirit**

Elizabeth believed it was important for her to recognise and accept that she was part of a family with a history of depression and that depression would always be a part of her life. As she said, she came to recognise it and to say “Oh, oh so there it is again”. She and her family learned ways to incorporate this experience into their lives without serious disruption. Elizabeth explained:

*.... later, when I could actually say “Look I’m just really depressed right now.” And “I just need to go there” and I learned that the way that I could resolve the depression is to actually allow it to happen and not fight it. And .... that can be quite hard at times, but it, at the end it worked for me. Eventually. Well it still does work actually.*

One thing that helped Elizabeth to become more aware and to accept depression as part of her life was her involvement with psychosynthesis both as a client of a very good therapist and in later years as a trained therapist herself. She talked of her therapy as being “extremely helpful”. This experience helped her to find answers to the questions that she had, as a “curious person”, asked herself for many years; “Like what was life? How, how do we do life?” The questioning that arose from therapy connected with her leaving her husband and her teenage and young adult children and travelling to Europe. She did not really know why she was doing this, but described to me a time which has been central to her getting the formula right:

*it was a really powerful time for me, getting in touch with, sort of spiritual things. I went to.... I mean churches found me, I didn’t find churches. I would just, I every church I could find I was in. And it was a hugely uplifting time for me. And, realising that aspect of my life has been was that was the start of the journey.*

Elizabeth spent her time often just sitting alone in churches and the meaningful experience was more about meditation than religion. She seldom attended services. She reflected on how “wonderful” and how “profound” this time in Europe was for her. She returned to her family, and set about changing her life radically. She questioned

everything about her life, and saw much of it, including the career in which she had been earning “*thousands of dollars a year*” as superficial. She sought advice about finding work with people, and after a few years discovered psychosynthesis and undertook the training, which she described as “*just perfect for me*”.

Depression continued to interrupt, but not seriously disrupt Elizabeth’s life. She experienced it differently and felt she had a choice about how she reacted to it. As she explained:

*I guess too that in our society we have this, sort of quick fix mentality, you know, well yes I’ve got depression but I’ll do this, this, and this and “then it will go away” and its actually not like that. I mean I could still have experience of it when I’m eighty, and that’s OK, its just saying that that is OK.*

**Ruth: “depression is part of being human... its getting the formula right at any given time, and trusting it”**

Ruth’s story and her understanding of her recovery started this chapter. I will now present a brief summary of how she got the formula right, so it can be situated alongside the stories of the other women. Her formula involved a “*wonderful therapist*”, exercise, diet, medication, self-care including reducing work stress by taking time out and then working part-time. All of this took place against a background of support from family and friends. Although Ruth could see particular triggers for depression seriously disrupting her life, she held a belief that “*depression is part of being human*”. What she strived for was to bring it under control so that her life was not seriously disrupted. She held no expectation that she would live free of this consequence of life’s stresses.

Ruth has sought out and cultivated the “*right sort of friends*” and for her this meant people who have a “*more metaphysical type sense*”, people with whom she could share meaningful and personal conversation. The counsellor she discovered later in her life, and whom she referred to as “*my Merlin*” also has a very sensitive side. He was direct but he also worked at a deep and metaphysical level with Ruth. She knew that she had inherited a special metaphysical gift from her grandmother, and saw this as a “*highly developed sensual system*” which enabled her to “*pick up a lot of information around me*”. At times this was frightening, but she came to see it as a gift she needed to cultivate and treat with respect. This special wisdom enabled her to “*be more fully*” herself. The counsellor and her doctor helped her to find the right medication, and she



acquired this from overseas if that was what she needed. She also took “*herbs*” and was checked out by a “*kinesiologist*” twice a year.

Physical well-being was very important, and when she was younger Ruth was a champion swimmer. At the time of the interview she was starting each day with a “*strident walk*” even when it was very hard to get out of bed and get started. She took part in a variety of exercise, including a developing interest in climbing. She monitored carefully what she ate, and knew that “*too much coffee, too much meat*” could trigger off “*low feelings*” often preceded by migraines.

Ruth acknowledged how common an experience depression is, and that it could at times be very “*simple*” but she believed it had enriched her life, as well as disrupting it:

*So that's where I'm at. To me it is being really truthful with yourself, and knowing that it's OK actually to be depressed. Because you are going to be depressed sometime, you find out a lot of things, and you detect it in other people very quickly. You become very, very sensitive and very aware that many people out there live a very stressful frustrating life, and many people have a lowness that they are frustrated with, and they probably pop Prozac. Which isn't the answer. Is it?*

For Ruth depression was “*an old friend that's very useful. But when it takes over it is just awful*”.

### **Hine: “the antidote to depression is hope and dreams”**

Hine spent many years discovering the formula that worked for her which included therapy, education, developing a relationship with her god and her tupuna and ensuring that she was nurtured.

Hine sought out counsellors for “*a number of years*” before she found one who was “*too good to be true*” and who worked in a deep and complex way on more than the “*immediate kind of problem*. ‘*Cause a lot people can be empathetic but it takes real skills to be able to shift you into being able to be proactive about your life.*” Alongside the therapy Hine became a volunteer with Rape Crisis, and was encouraged to begin formal tertiary education. Her academic ability and her commitment to education over many years gave her choices in her life, and let her consistently experience “*hope*” and to “*effect*” her own “*agency*”.

The formula that worked for Hine included a spiritual element; firstly she saw a “*clairvoyant*” and then a “*tohunga*” which enabled her to communicate with the

“spirits”. Her “god self” was able to get in touch with her “good self”; language she repeated often:

*I became whole again and more integrated, I hooked back up to my god-self - that's when I started to tune in more to spirit and develop more of a relationship with god and the tupuna and I haven't looked back since then.*

Hine recognised that to continue education, her profession and to maintain her spiritual life she needed to care for herself. She was able to attend a ‘retreat’ house for women which provided “good food, good attention, company”. The experience gave her things she believed “a lot of women” need when “they’re depressed”: “loving” and “lots of nurturing”. She described in detail how she experienced nurturing:

*You didn't get out of bed in the morning until you'd had your morning tea.... you were waited on. I took some theory books out and I wasn't allowed to read them. which was marvellous. You were allowed to walk on the beach, go round the shops. It was just wonderful. You don't do any vacuuming, you don't have any responsibilities...Lack of responsibility .... so for me as a mum of three children and at university, I think it was .... a complete break from everything but it was the nurturing. It was knowing that there were other people there to take care of things and that my lunch was made for me, my breakfast was brought to me, I mean just that loving, that nurturing was just wonderful. That's what we need more of.*

Not everyone can recover the way that Hine did, and she was very aware of that. She came to believe in herself as “multi-talented” as having “more choices”, and knew that her mother was part of that. She “freed me up to think quite eclectically and laterally about a lot of things”. Hine became a counsellor, a business woman and an academic. The advice she gave to her clients was:

*Trust your own women's energy. Listen to that before you listen to your GPs or your counsellors or your mothers or your husbands or your lovers or your lesbian partner or whoever, Trust your own wisdom because that is right for you and everybody. I believe everybody is a holy child of god, everybody is divine so everybody's wisdom and knowledge is made just right for them.*

### **Naomi: “I choose life and not death”**

Naomi was clear that being a second generation holocaust survivor had a very significant impact on her life, and that she had needed to find a way to move beyond the “script” that “It's more OK to be depressed than it is to be successful and get on with

*your life*". Her formula was complex; *"a myriad of things"*. It had a focus on her body and she needed to learn to live with herself as a woman, a mother and a person of worth. A context of companionship and acceptance, especially amongst women was important.

As our interview drew to a close Naomi said *"I still want to plug this physical thing. Because somehow the body thing, that I think depression is..."* she described the body as a *"humungous"* aspect of her recovery. She *"started to walk"* and reflected *"that has made progress a lot faster"*. Walking had been really *"profound"* and symbolic of her being *"able to say, I choose life, and not death"*. It meant that she could *"breathe the air ....it's a life thing, walking, its life."*

The commitment to walking was also a *"soul"* thing for Naomi. Therapy worked on her *"mind"* and that did *"a hell of a lot to a lot of degrees"* but not enough. It:

*doesn't manage to get down into that soul, you know, place inside. That place inside that probably started many generations ago. And it just sits there. Eh? Inside. I have this vision of it somehow it's a little acorn. You know, inside.*

Walking regularly enabled Naomi to get into this deep place and to make other important decisions about self-care. One she described as a *"biggy"* was to stop wearing a mask and to be herself with all her fears. Reaching this point was a *"slow, winding process....something like twelve years of it"*. She claimed an entitlement to *"love and enjoyment"* which encompassed working with people in the natural, wilderness environment. Removing the mask enabled Naomi to *"do some proper grieving, which is healthy"*. She believed that being able to grieve for many things in her personal life and her heritage enabled *"depression"* to *"turn healthy"*. She learned to acknowledge that not only her body, but also her *"superb mind"* assisted her to make dramatic changes.

People have been an important context for her recovery. Naomi found acceptance from counsellors, both her own therapists and colleagues in training. She also found it amongst women in the Jewish community. Many levels and sites of acceptance were valuable in her growing self-acceptance. She had to consciously work on *"observing, observing what you do"*, not *"judging"* and the practice of just *"noting"* what she was doing *"without any kind of "don't be stupid"'"* has been very helpful in her *"transition"* to acceptance.

Behind the work and the self-awareness there has been one constant in Naomi's life throughout her years of recovery. Her child has been a significant motivation for her to keep working to overcome the disruption of depression, to find a way to live well in spite of being a second generation holocaust survivor.

*I brought him into the world and I owe him, I owe it to him to do the best I can for him. And also not wanting him to repeat what I've got. So that's --- I need to break the cycle, huge stuff.*

It mattered very much to Naomi that the heritage of depression that she traced back through generations could stop before it disrupted her son's life. She chose life for herself and for him, even though the choice and the consequent actions have been at times extraordinarily difficult.

## **Conclusions**

The Figures included in this chapter highlight one significant pattern that can be discerned in the women's narratives. The way that women talk about their journeys through a life disrupted by depression varies enormously. At one extreme is Charlotte's story which contains one episode of depression in the middle of her life. At the other extreme is Naomi who talks of depression as coming with her into her life when she was born, and stretching back through generations. In a similar way the times after the worst disruption sometimes seem depression free, or as Linda said "*from that point on I stopped feeling depressed*". For other women, such as Ruth, depression is "*an old friend*" who continues to be a part of her life, and she expects always will be there. These patterns will be discussed in greater depth in the final section of the thesis.

Another feature of the narratives as they have been presented in this chapter is their links to the historical time of the worst disruption. A significant aspect of this concerns gender, and again this will be discussed fully in the next chapters. The Figures allowed me to see easily that some women had experienced the worst disruption in the times before the impact of the second wave of feminism. These women, including Charlotte, Hannah and Katy, had expectations of life that were different from those of Kate, Linda or Marge. These different expectations were partly linked to the positions available to women in these very different historical times. The construction of women as wives and mothers which was dominant in the nineteen fifties and sixties was more complex by the eighties and nineties. Women were more able to call on the stories of women who could 'do anything' including choosing not to have children, living in

same sex relationships, expecting to have a successful professional career and perhaps to combine this with successful mothering. Whilst these stories evolved there remained, perhaps, a dominant story of woman as nurturer. Woman as caregiver to friends, family, clients, but not to herself. Again this issue of entitlement will be explored further in the Conclusions to the thesis.

In this collection of narratives about ‘getting the formula right’, concerns complexity, a final noteworthy theme concerns complexity. As Ruth suggested in the opening ‘poem’ the formula is multi-faceted. It is also unique to each individual woman. Some things thread through all the formulae, however, and one of these is the holistic nature of depression and of recovery. The approach of Mason Durie, discussed in Chapter One, is clearly applicable to these women’s understandings of their lives with depression. The journey into the worst times, through those terrible times and on into recovery involve the four dimensions of ‘hauora’ (well-being):

- Taha Tinana – physical well-being
- Taha Hinengaro – mental and emotional well-being
- Taha Whanau – social well-being
- Taha Wairua – spiritual well-being.

The important conclusions which link the stories in this chapter with those in the preceding findings chapters will be presented in the last section of the thesis – The End. In this final findings chapter I chose to present each woman’s story to emphasise the uniqueness of each journey. Whilst patterns and themes emerge and are useful, it is important to me as a clinician as well as a researcher that I honour the special nature of each woman’s journey. It is only from paying close attention to the nuances and emphases of each story that it is then possible to step back and see possible patterns; patterns which will be discussed in The End.

# THE END

The two chapters in this section present my conclusions and recommendations. Chapter Eleven draws on the analysis presented in the five findings chapters and positions the conclusions that I have drawn from this analysis within some of the literature reviewed and discussed in The Beginning section of the thesis. The work in this chapter is in part informed by the discussions I had with the group of five women as I was beginning the analysis. Chapter Twelve is brief; in it I discuss the limitations of this research as I see them, and I make recommendations based on my research for clinical practice, mental health policy and for further research.

## Chapter Eleven: There's no meaning in chocolate

Hilary: *What is the difference between chocolate, cigarettes, good sex and these other things you are talking about like music and astrology?"*

Ruth: *I think because it stimulates a deeper thing – if you're open to it. That's why it can be scary, and yet so powerful and healing.*

Naomi: *I'll tell you what's different – is that chocolate and the smoking – I mean, they, they stifle --- it's comforting, it's great, and it's got it's place, and I wouldn't be without it, but it actually puts a, it puts a lid on it, whereas those other ones open it, that makes it more OK.*

Chloe: *I know what you mean, it's sort of like – it's only a top layer – music's all. Everything.*

Anne: *Like, I can smoke – I can chain smoke – no trouble whatsoever. But, I, it doesn't do anything for me. I've still got this anxiety about linking in with something that gives it, a, a meaningful – the key word is meaning.*

Karen: *There's no meaning in chocolate.*

The conversation that introduces this chapter is taken from the second group meeting. Hilary was curious about the discussion which had been taking place in the first two sessions. The women were talking about their recovery and about the solutions that had worked for them. They were all in agreement about the distinction between the symptom relief of chocolate and smoking and the more profound solutions which gave meaning to their lives and went below the surface. This concept of different levels of recovery is one of the significant conclusions that can be drawn from this project.

### **Introduction**

Throughout the analysis of the narratives I have experienced a tension between acknowledging the unique, contradictory and situated nature of each woman's story and recognising and communicating understandings that can be gleaned from exploring all eighteen stories as a group. Distilling and drawing commonalities from the stories honours the women's reasons for taking part in the research. They wanted to offer suggestions which could assist other women to recover their lives from the disruption of depression. For the majority of the thesis I have rejected 'grand' and 'totalizing' narratives, focussing instead on "individual subjectivities" (J. M. Anderson, 2004,

p.238). As Frank (1992) advocated I have born witness to the “embodied” and “eccentric” nature of the women’s suffering (p.483). In this chapter, however, I am offering understandings which may lead to change and to respectful and effective clinical practice and policy-making.

I will discuss some conclusions that I have reached from my analysis of the women’s narratives. The four conclusions that have emerged as most significant are that:

- for these women many experiences of depression and recovery are linked to ‘gender’,
- the women talk about two different, but overlapping, kinds of solutions involved in recovery:
  - the ‘chocolate’ solutions which offer symptom relief,
  - the discovery or re-discovery of a way of making meaning of one’s life which results in a more lasting recovery,
- there appears a kind of symmetry in many of the journeys toward and beyond the worst times of depression,
- the women talk of their lives with and beyond depression in an holistic way with a regular awareness of context.

Following discussion of these major findings I will review some issues that have emerged concerning the women’s agency and their resistance to the readily available and powerful professional narratives concerning depression and recovery.

### ***Many of the women experienced depression and recovery as gendered***

In ‘The Beginning’ of this thesis I reviewed research and theory which argued a strong case for depression being gendered. This project was designed with an assumption that women’s experiences around depression would be different from those of men. The women’s narratives supported this assumption, and offered some particular insights into how being a woman impacted on:

- the ‘jolly good reasons’ for being depressed,
- the resilience factors involved in recovery,
- the ways that women might begin to ‘crawl out’ of their worst times
- the ‘formulae’ they worked out that enabled them to live a life no longer seriously disrupted by depression.



It emerged that the manner of this impact depended also on the historical context.

### **Historically situated gender issues**

The possibility of exploring the way that women's narratives are historically situated was discussed in Chapter Four (p.77). Kirkman (1999), Riessman (1993) and Plunkett (2001) all stressed the importance of context in the way that women construct their positions narratively. The context is not only geographical and cultural, but also historical.

In this study I was able to collect narratives of women who had experienced depression and recovery throughout the past half century. The stories that are most readily available to women about how to live a meaningful and satisfying life vary according to the historical time. Charlotte, Hannah, Katy and Fiona, for example, entered adult life before the seventies and second wave feminism. Their narratives suggest that the stories which called out to them were different from those available to younger women such as Linda, Marge and Katy.

For the older women the meaningful story of their youth often involved becoming good wives and mothers. When this story was disrupted through loneliness and isolation following child-birth (e.g. Katy and Charlotte) or an unfulfilling marriage (e.g. Hannah) then depression was one of the consequences. Recovery involved discovering a different way of living a meaningful life as a woman. Winslade and Monk (1999) suggested that "human beings live their lives according to stories" and these stories "are not produced in a vacuum" (p.21-22). Many of the women continued to live their lives according to the familiar stories of 'good mother' but were able to find alternative stories that also called out to them. This enabled them to find additional meaning making activities to include in their lives.

Hannah left her marriage, found meaning in spirituality and a variety of creative arts, and eventually entered a more satisfactory marriage. She managed to retain a life as a loving mother. Katy and Charlotte stayed within their marriages, but found ways to reduce their isolation and discovered meaning in other ways of living and storying their lives. Charlotte extended her nurturing activities beyond her immediate family and became involved in caring social activities, including the Guiding movement and fostering babies. Katy continued to centre her life around her faith and her family but also engaged in a growing level of involvement with animals on her small-holding.

Some of the women who had children in the late seventies and eighties, after second wave feminism, found there were different narratives of successful women that they could draw upon as they recovered. These stories would not have been as readily available when they were in their twenties. Kay, Hine and Christine were amongst the women who found that they were intelligent and capable of achieving in tertiary education as well as being mothers and sometimes partners.

Stories about paid careers for women were also more available after the nineteen-seventies. For some of the women living out such possible stories enabled them to earn money and thus have more choice (e.g. Hine) but for Marge, and to some extent Fiona, the possibility and perhaps the expectation of having a very successful professional career created stress. They both commented on this as part of the reason for depression disrupting their lives.

The findings demonstrate the variety of meanings that different women attached to aspects of their context. Frank's ideas of 'narrative habitus' (Frank, 2002a) offer a way of understanding this variety. The stories that call out most persuasively to each woman will be influenced by their own social and historical context, but for all the women contextual matters are significant. An aspect of the storying of their lives which relates to gender and to history concerns women and their sense of entitlement. I will review this aspect of the study next.

## **Entitlement**

A number of the women referred specifically to their own awareness of gendered issues. Ruth, for example, considered "*being female*" one of the reasons she became depressed. Usually being female was talked about as a difficulty to be overcome rather than a strength. Only when the women found the 'right formula' to free themselves from the disruption of depression, did they begin to talk of their gender as an acceptable or even a positive aspect of their lives. The lack of a sense of entitlement is one idea which is attached to gender and which emerges from many of the narratives. This aspect of the women's stories is consistent with the findings of Schreiber (2001). Schreiber found that women who experienced depression had often tried to be "good women" which meant being "selfless" and "self-sacrificing" (p.88), and having little sense of entitlement to meeting one's own needs, be they physical or emotional.

Childhood experiences of violence, sexual abuse and emotional neglect were common amongst the women, as was discussed in Chapter Seven. This was the most

significant gendered aspect of their ‘jolly good reasons’ stories. In their recovery stories the response to these experiences involved the women acquiring a greater sense of entitlement to a fulfilling life. Thus Hine, who talked specifically of sexual abuse in her childhood and adolescence, included in her recovery story the growing awareness that she was entitled to make choices about her own life. The content of the stories of entitlement varies for different women, perhaps reflecting their own ‘narrative habitus’.

Fiona’s motor-bike riding is a clear example of a changing sense of entitlement linked to her gender and situated in a changing historical context. When she was young Fiona worked with her mother to prepare meals for the male members of the family to go adventuring on their motor-cycles. At that time in her life she was “*just a cute little girl thing that didn’t go and take the world on*”. Her language is significant; she names her self a ‘thing’ and describes herself as ‘little’, but her gender is clear. She is a ‘girl’ not a ‘child’ or a ‘kid’. Decades later the historical times have changed and lots of women are riding motor-cycles, and so is Fiona. By the end of the twentieth century all kinds of fascinating, vivid and unconventional women can ride motor-bikes and so can Fiona as she lives with a very different sense of her own entitlement.

Other stories involved growing awareness of entitlement; to education (Hine), to autonomy (Isobel), to driving the family car (Katy), to working for less money and status, but also less stress (Marge) and to leaving an unfulfilling (Kay) or violent (Naomi) marriage. These stories are consistent with Dana Jack’s theory and research about the place of ‘silencing the self’ in women’s experience of depression (Jack, 1991). In my research the emphasis has been on women finding a way out of the silencing; having a voice, and for some, like Fiona and Kate, living a life out loud.

### **Feedback from the group**

The gendered nature of the depression experience was not specifically discussed in the group meetings. At the time of the meetings I had not focussed on it as an issue but was taking for granted that gender mattered. Although all the women in the group (Anne, Chloe, Karen, Naomi and Ruth) included gender issues in their individual narratives, they did not discuss these together.

### ***Chocolate solutions and the creating/re-creating of meaningful lives***

This chapter opens with a segment of the discussion amongst the five women at one of the group meetings. This understanding of the differences amongst responses to

depression came to me from the group. It was not something I had recognised at that time in my early readings of the individual narratives. Once it had been discussed at length by the five women, however, I returned to the narratives and found it was an idea that helped to make sense of much of that talk. It was this notion which helped me to evolve the two different chapters on recovery.

The women in the group suggested that different responses to depression resulted in different kinds of relief. There were ‘chocolate solutions’ which offered symptom relief, and there were more complex ‘solutions’ which supported the women to find meaning in their lives. Anne, for example, talked of astrology as the “*meaning-making map*” in her life. Chloe’s story which I used to introduce Chapter Nine offered a clear illustration of the differences. For her the homeopathic tablets worked like magic to lift a “*black cloud*” and to allow her a feeling of “*euphoria*”. She then needed to work long and hard as she came to “*face myself*”; to discover meaning in her life.

Professional recommendations for the treatment of depression often involve a range of different responses according to the perceived severity of the depression. In New Zealand, for example, the National Initiative on Depression (Ministry of Health, 2007) recently stated:

Different types of depression require different types of treatment. This may include physical exercise and other self-help strategies for preventing and treating mild depression, through to counselling and drug treatments for more severe types of depression.

As has already been discussed in Chapter Six, all the women in this study would have earned a classification of major depressive disorder. All recovered. But for these women the ‘treatment’ was more complex than a combination of medication and talking therapy.

### **‘Chocolate Solutions’**

The ‘chocolate’ solutions of symptom relief are a focus of Chapter Nine and its stories of the beginnings of the journey out of the worst disruption of depression. Chloe found homeopathic remedies a ‘chocolate’ solution for her, and for other women this level of solution includes the mainstream treatments of antidepressant medication, and different experiences of talking therapy. Thus, whilst prescribed antidepressants were ‘false starts’ for women such as Isobel and Anne, for other women, including Hannah, Jane and Kay they helped them to sleep, or calmed them down. Talking therapies led to a beginning of recovery for some women. Kate, for example found counselling helpful to

get her started before she discovered the body work that went really deep and was the central feature of her 'formula' for recovery. For eleven of the women, including Anne, Ruth and Marge, talking therapies were central to their formulae for recovery.

The stories of effective 'chocolate' solutions that come from outside mainstream treatment are varied, and each fits within the particular woman's context, and 'narrative habitus'. Chocolate was actually mentioned by four of the women, as well as being discussed by the group with enthusiasm. Other complementary solutions worked as symptom relief for some, but not for others. Skaersaeter et al. (2003) and others have shown that physical exercise can help with recovery from depression. However, this is not the case for everyone; Marge and Naomi had contrasting experiences of the place of exercise in their lives. Naomi talked of walking regularly as being very important as a beginning of recovery. Marge, on the other hand, found that sleeping when she needed to was really important, and commented on the absurdity of the advice in self-help books to walk; *"when you're depressed the last possible thing I want to do is exercise"*. She did however, realise that this might work for other people: *"Maybe there's somebody out there who does, who you know that works for them"*.

I have focussed on exercise, but Chapters Nine and Ten offer many examples of complementary 'cures' that have worked for different women. They also provide stories of activities and ideas which have worked to help women stay free of symptoms. These things have been embedded in the context of each woman's life. Thus Isobel talked passionately of the place of needlework and the piano in her life (p.190). The needlework in particular was not mentioned by anyone else, but it was pivotal in her recovery, including her decision to stop taking medication. The stories of how the women discovered and rediscovered meaning in their lives are even more complex, supporting the assertion of Ussher that we should abandon attempts to predict "the effectiveness of one treatment" (2000a, p.222).

### **Creating/re-creating meaningful lives**

The major finding emerging from Chapter Ten is that each woman found the 'right formulae' to live a life no longer disrupted by depression. A major part of this formula was the discovery of meaning in their lives. This is in accord with a lot of other research about women and depression. Crowe (2002) found that in recovering women were able to "establish new significance and meaning in their lives" (p.131). Steen (1996) talked about women in recovery from depression becoming gardeners and

“cultivating the self” (p.87) which involved finding new meanings in their lives and Skaersaeter (2003) named one of the four categories of women learning to cope with depression as ‘finding meaning’.

The ways that the eighteen women in my study found or created meaning in their lives varied. I mentioned Anne’s discovery of the meaning-making map of astrology. This was also a source of structure and meaning for Chloe and Karen. Psychosynthesis was a common way of finding meaning for several of the women, especially the work published by Grof and Grof (1989). When I invited the women in the group to bring symbols of their recovery from outside the main stream, two of the five women brought this book, and a third said she had looked for her copy to bring but been unable to find it. The book was also mentioned by Elizabeth and Marge who were not part of the group. This suggests that the approach to mental illness as a ‘spiritual emergency’ is one that offers meaning to many of these women.

In the earlier section on gender I have discussed how many women discovered new stories to live by so as to become fulfilled women; stories involving entitlement were amongst the most important. Connectedness in its fullest sense was also important. For some women, including Chloe, Hannah and Ruth, this came in part through finding a new partner who respected them and who was able to communicate meaningfully. For others it involved making meaning of an important aspect of their ‘self’. Hine needed to reconnect to her Māori self, Naomi to her Jewish heritage and Karen had to find a meaningful way of including her disabling condition in her ‘self’.

The processes of finding meaning were also varied. Where Naomi and Kate needed to begin to connect in a significant way, Elizabeth needed to take time away from even her closest family. Steen (1996) wrote of women needing to “withdraw to conserve her energy” (p.77), and Marge and Karen both talked of this on a daily basis. For Elizabeth, however, there was a need to withdraw for months to Europe and to sit alone in quiet churches while she allowed herself to discover meaning for her life.

These different meaning-making processes themselves suggest an interesting pattern in some of the stories, and this is the next conclusion which I will discuss.

### **The women’s meaning-making narratives as a basis for different recovery journeys.**

The impact of any particular ‘recovery strategy’ seems not to depend on the severity of the depression. For these eighteen women the aspects of their stories which were most

similar were evident in the way they talked of the worst times. On the basis of those stories and common professional advice one might expect that their recovery would involve a combination of medication and counselling. Yet this was not the case. Rather, the duration and complexity of the recovery journey related to the complexity of the story each woman told about her journey into the most disrupted time.

### ***'Symmetrical' nature of journeys into and beyond the worst disruption***

One aspect of the women's narratives that I was conscious of throughout the analysis was the idea of 'turning points' in the recovery journey. I had long been aware of the idea of 'fresh start' events which Brown and his colleagues had found to often precede recovery (G. W. Brown, Adler, & Bifulco, 1988). In New Zealand the Kia Mauri Tau project (Lapsley, Nikora, & Black, 2002) had identified "turning points" in "nearly all the narratives" (p.48). Both the fresh starts and the turning points "appeared to herald hope" (G. W. Brown, Adler, & Bifulco, 1988, p.490).

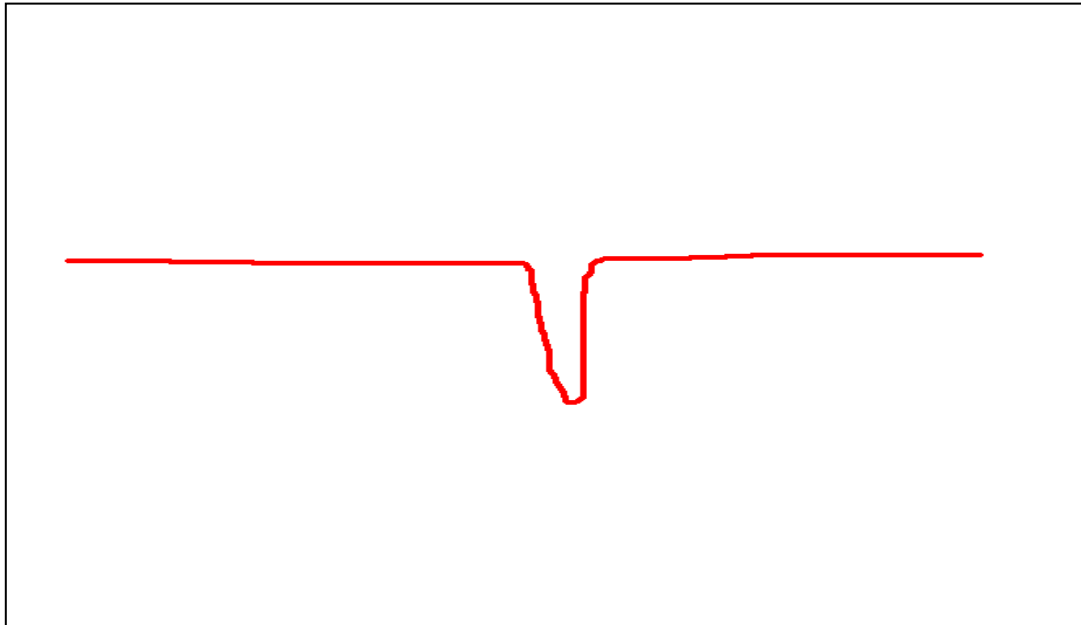
One way I explored the long-term patterns in each woman's narrative was through graphs as discussed in Chapter Four (p.79). As I drew graphs to represent the extent to which depression was disrupting each woman's life I was originally looking for 'turning points'. Tuval-Maschiach (Lieblich, Tuval-Maschiach, & Zilber, 1998) carried out visual holistic analysis of adults' lives while exploring the impact of different kinds of high-school experiences. She acknowledged the difficulty of representing graphically the "intricacy of plots" (p.89) but still found it a useful way to uncover some aspects of the women's journeys through life.

Unexpectedly, with a few exceptions, turning points did not seem to be a significant aspect of the narratives of the women in my project. The graphs I drew (Appendix N) along with the stories of getting the formula right (Chapter Eleven) suggest a pattern connecting the stories of the journeys into and through the worst of depression with the journeys of recovery. The pattern is one of 'mirrored' or 'symmetrical' journeys. These patterns are best illustrated by focusing on a few of the women's narratives.

### **Lives severely disrupted, but for a relatively brief time**

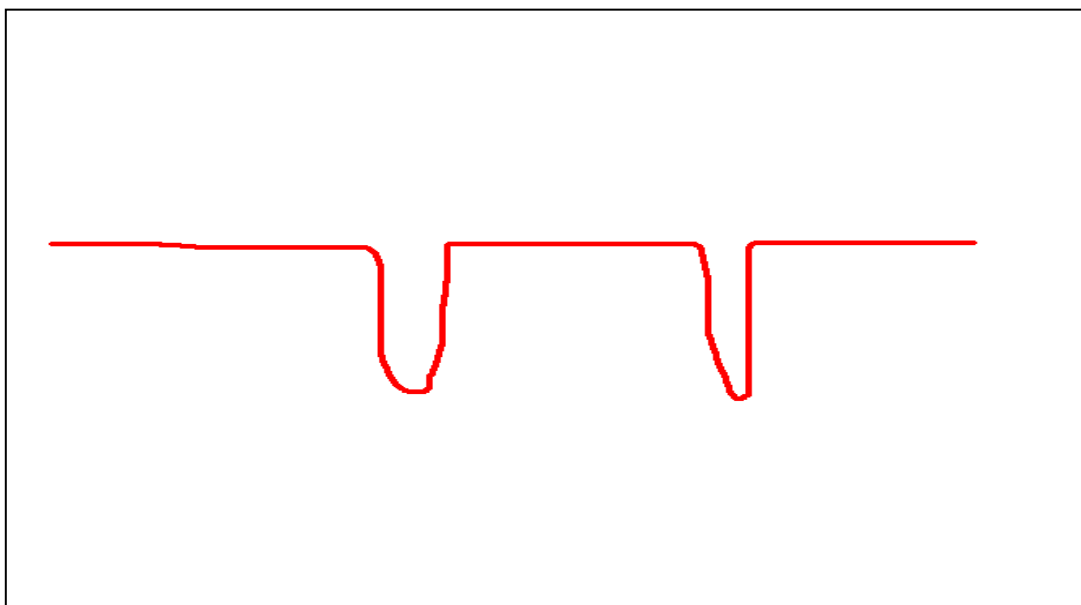
Jane talked of her life being only briefly disrupted by depression. She said "*a major episode which I've come through and I'm out of. I think I'm one of the 50% that don't relapse*". She had earlier said that the depression came on quite suddenly when her

husband left her. When I studied her whole narrative I represented it as shown in Figure Eight.



**Figure Eight:** Jane's journey before, through and beyond depression.

Katy's 'pattern' was similar but involved two episodes of depression (Figure Nine).



**Figure Nine:** Katy's journey before, through and beyond depression.

Both Jane and Katy talked in their narratives about the sudden invasion of their lives by depression. In Jane's case this followed marital separation. In Katy's life the first time was triggered by issues related to child birth and isolation, and the second to stress

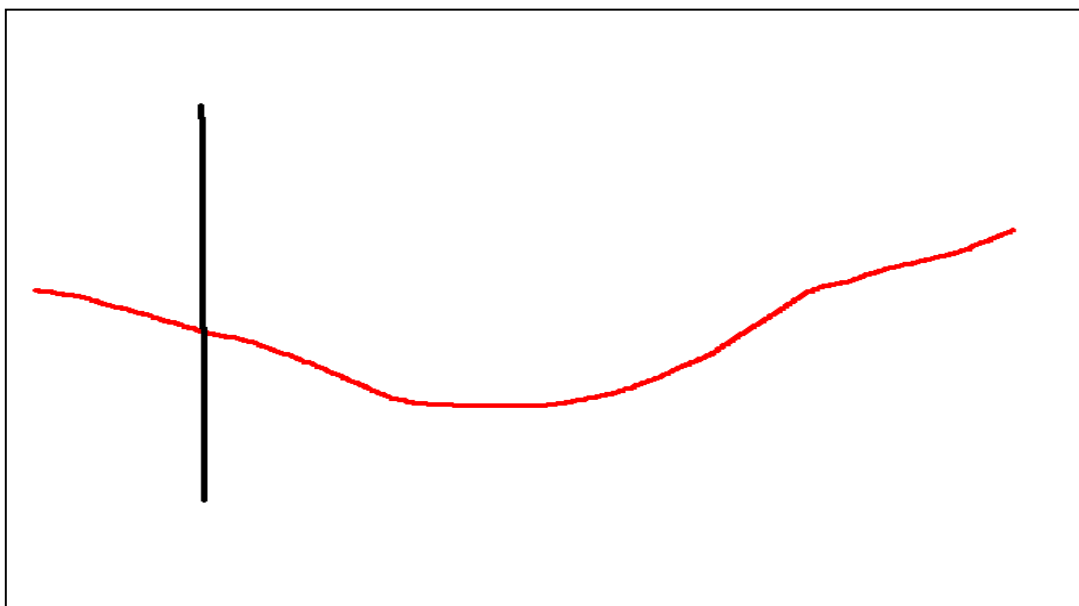


around organising her daughter's wedding. They each talked about their recovery as relatively simple. Jane's recovery centred on attending a group and reading books. Katy's recovery from the first episode involved reducing her isolation, and the second came about through homeopathy.

Other women who had a relatively small proportion of their life time disrupted by depression were Charlotte, Hannah and Kay. The graphs I drew to represent their journeys have similar patterns to those of Katy and Jane.

### **Long and complex journeys into and then beyond the worst disruption(s) of depression**

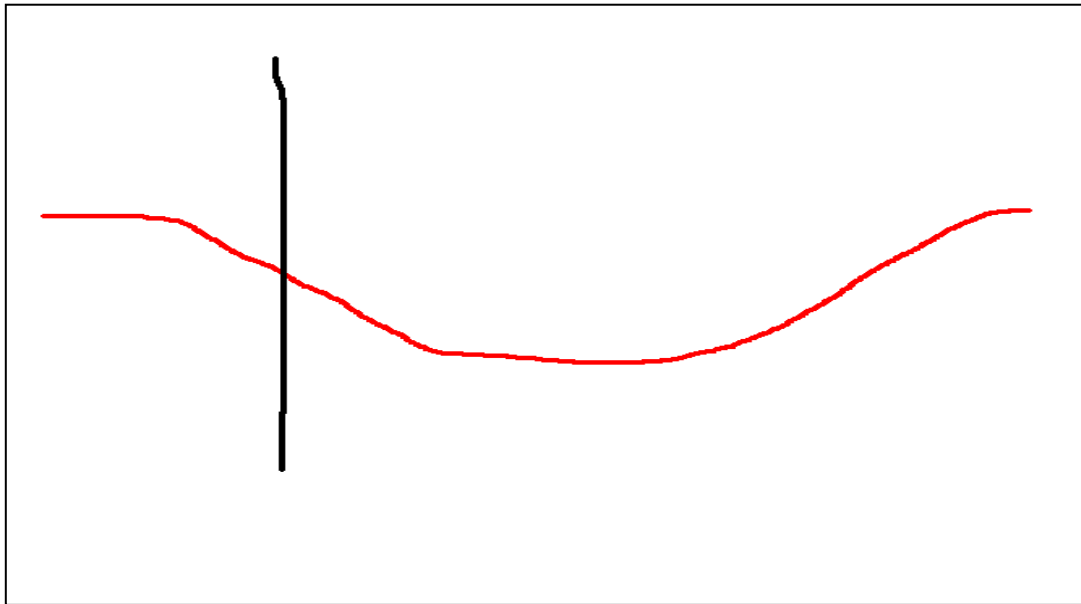
Nine of the women had narratives which followed a very different pattern. I will use Naomi's narrative to represent the patterns which emerged for her, but also for Hine, Elizabeth and Ruth. Naomi's journey into depression began generations before her birth, and was "*holocaust*". Her journey of recovery has also been long and complex involving geographical shifts, therapy, physical experiences, training for a new career and many other things. Figure Ten is my graphical representation of that journey, with the vertical line representing Naomi's birth.



**Figure Ten:** Naomi's journey before, through and beyond depression.

Elizabeth also talked of depression coming to her from her parents and grandparents as well as being impacted on by her own life circumstances. Her journey of recovery involved spending several months in Europe, taking antidepressant medication, having psychosynthesis counselling and many other things. She felt that

depression was still a part of her life, but a part she could manage so it was not seriously disruptive. Her graph was similar to Naomi's.



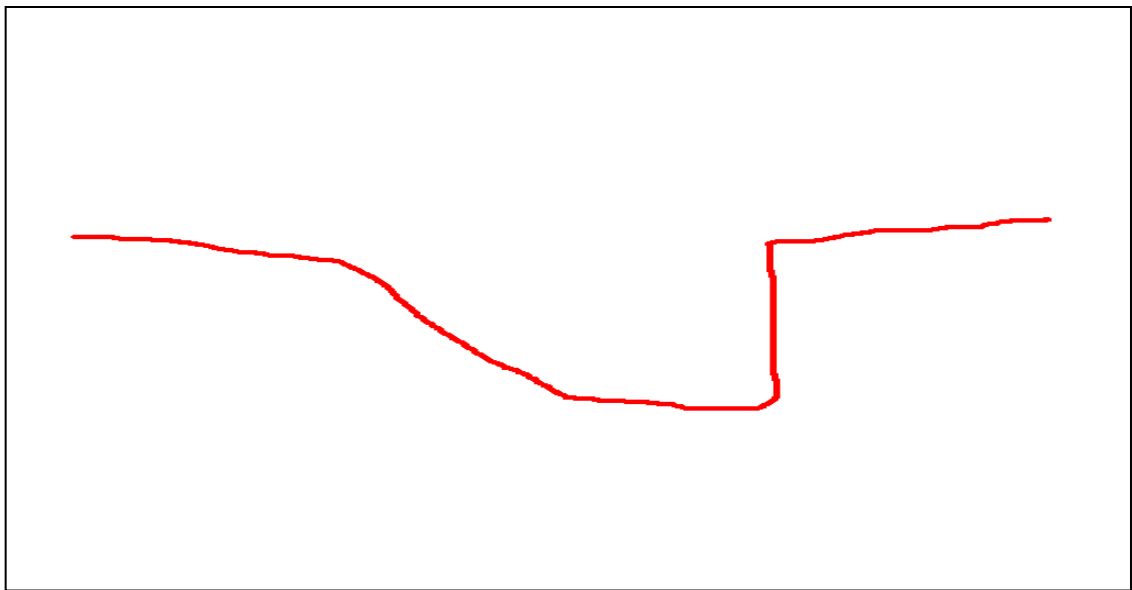
**Figure Eleven:** Elizabeth's journey before, through and beyond depression.

Other women whose journeys followed similar patterns to those of Naomi and Elizabeth, were Karen and Hine. Karen's 'graph' started just before her birth because of the involvement of her disabling condition. Hine's narrative focussed in part on her Maori ancestry and the consequences of being part of a marginalised and colonised ethnic group. When Ruth told her story she focussed in part on the consequences of being female, thus her graph also begins with her birth.

### **Group feedback**

I had not noticed these patterns until a long time after the group had met, so did not invite them to discuss the idea. The five women did however spontaneously discuss the complexity of their recovery, and as indicated in the previous section they commented on the differences between symptom relief and the more complex meaning making. Many of the longer journeys of recovery involve a complex search for ways of making meaning of a life which had perhaps never really had a sustainable and satisfying meaning, even before the worst disruption of depression. Thus women who experienced abuse and neglect from an early age (e.g. Anne and Chloe) did not talk about having a meaningful life before depression.

All but two of the women's narratives (Fiona and Linda) support this idea of a symmetrical pattern, although in some ways it ignores the complexity of all the lives. I do believe, however, that it could offer a useful possibility for clinicians. One narrative which clearly does not follow either of the two patterns discussed is that of Linda. Her 'graph' looks very different, with a long journey into the worst time, but a very sudden journey out. Once the specialist had given her a clear diagnosis and treatment plan for her physical condition she 'recovered'. As she said: "*from about that point on I stopped feeling depressed*".



**Figure Twelve:** Linda's journey before, through and beyond depression.

The graphs I have presented, showing journeys through and beyond depression for five of the women, focus on the times before and after the worst disruption. I commented in Chapter Six that the times of greatest disruption were the times when there was most similarity amongst all the women's stories. Mainstream diagnosis of depression tends to focus on this worst time and on the symptoms that are evident then. The treatment recommended almost always relates to the assessed severity of the depression. My findings challenge this kind of recommendation. The analysis of the narratives that I have just discussed suggests that treatment and recovery may be connected to the way that the women understand and talk about the 'jolly good reasons' for their lives being disrupted by depression. They may also relate to whether the woman feels that her life ever had meaning and fulfilment. The meaning of life is an holistic experience for the women, and this is the final aspect which I will discuss.

### ***The holistic experience of living with and without depression***

The narratives of the eighteen women in this study all support the importance of viewing depression and recovery in an holistic way. Mason Durie's Māori model of mental health, using "paiheretia or relational therapy" (2001, p.170) offers an approach which is compatible with the women's experiences. The approach, often referred to as Te Whare Tapa Wha, encompasses taha Tinana (physical wellbeing), taha Hinengaro (mental wellbeing), taha Whanau (social wellbeing) and taha Wairua (spiritual wellbeing) (Headspace.org, 2007). Almost every woman in this study encompassed all these aspects in their narrative of recovery.

Physical wellbeing has already been mentioned in relation to walking and the contrasting experiences of Naomi and Marge. Chapter Ten illustrates, however, that many of the women talked about their bodies in their recovery process. For some this was very direct, such as Jane's taking up ocean swimming; for others including Ruth it was one part of a complex formula. For all, however, the experience of depression and of recovery involved their physical body.

Mental wellbeing is most commonly referred to in terms of recognition of an ability to think and learn. Growing awareness of this ability was at times reflected in women undertaking formal study (e.g. Hine, Kay, Christine, Naomi) and for others in their reading and discussing 'meaning of life' issues in a complex way (e.g. Kate and Hannah).

Social wellbeing was interesting. One issue that came up in the group was that few of the women talked about the need for relationship in their recovery. This had been shown to be an important aspect of recovery in another recent New Zealand study (Lapsley, Nikora, & Black, 2002). In the group the women talked about the personal nature of the journey to recovery. In the individual narratives this was also the case. Where relationships were important they were more in the role of support for the woman's journey. Thus Elizabeth talked of her family enabling her to go to Europe for months, and then welcoming her return. Marge talked of her partner accepting and supporting her need to work at a less highly paid job and to take to her bed and sleep at times for lengthy periods, ignoring the housework and communication. Other women, including Anne and Naomi have managed their recovery without having any particular close relationship, except with their children. Their children have been motivation for recovery, but have not directly supported the process.

Spiritual wellbeing in its most inclusive sense has emerged as an important part of all the women's stories. This matter was discussed at the group, and for those five women it was a central part of meaning making which was essential to recovery. This has therefore been discussed under the second conclusion. It seems important to add here that once this idea had emerged in the early interviews as one of potential importance I decided to ask about it at the end of subsequent interviews. Some of the women, including Katy, talked about particular religious beliefs and their importance. Others, including Christine, talked about a sense of the importance of the world of nature. For all of them, though, recovery involved the idea of seeing themselves as having a meaningful place in the world and sometimes on the Earth.

This holistic and complex understanding of depression fits well with the approach of many of the researchers whose work I reviewed in the last part of Chapter Three. It is also consistent with the 'quirky' views of the self represented by Sampson (1998) and Ussher (2000a). Stoppard (2000) suggested that depression should be recognised as an "integrated biopsychosocial phenomenon"(p.21). Having listened to the narratives of these eighteen women, I would want to add a metaphysical or spiritual element to this.

In the final part of this chapter I will briefly consider the ways that these women have managed to stand against the most powerful stories of depression and recovery, and listen to other stories which have called to them, and which have enabled them to move beyond the worst disruption of depression.

### ***Agency, resistance and 'narrative habitus'***

This chapter has emphasised the complexity of the processes of recovery as they have been talked about in the women's narratives. It is therefore not surprising that there is no simple story of resisting professional 'treatment', exerting agency and finding one's own formula for recovery. What I can do is recall the aspects of the women's stories which called out to me and which I found most compelling in this area.

First, however, I want to emphasise that this was a particular group of eighteen women. They chose to take part in a piece of university research, and they responded to a written advertisement in a place which implied community involvement at some level. Many of them talked of always being, or becoming during recovery, outspoken, 'feisty' women. Whilst this could be seen as a limitation of the study, I believe it offers an important story about depressed women; one that can counter 'myths' of the

depressed woman as helpless and hopeless. Nevertheless, it is clear from Chapter Six that all these women had experienced times of being very helpless and hopeless, as they curled up in foetal positions on the floor and engaged in a life characterised by ‘chaos’. The question is: How did they manage to move on from this place?

The data offer a rich source of material to do a further study focussed solely on this resistance stage of the narratives. That is not the focus of this project. Chapter Nine does offer some clues about the ways that women began to crawl out. The aspects I will discuss here involve happenstance, the intervention of an appropriately empathetic professional or friend, reaction to a totally unacceptable option or a slowly growing awareness of possibilities. All these opportunities worked in part because of the ‘resilience’ factors which the women had experienced before or retained throughout their worst times.

### **‘Happenstance’**

Many of the women talked about a ‘turning point’ as happening unexpectedly. The intentional part of the occurrence is their accepting the ‘offer’ and acting on it. What is less clear is what enabled them to act at that point. Two clear instances of this come from Kate and Charlotte. Charlotte had a young person arrive at her door selling Girl Guide biscuits. Charlotte was able, at that point in time, to reach out and offer her help to that community group. She talked of the visit triggering memories of herself in an earlier and happier time, and she was able to make the connection and come from her foetal position on the floor behind the couch to answer the door and then to make a tentative enquiry about positions as a volunteer. Kate also experienced someone coming to her door with books which became significant in her recovery, and also with information about a body-worker who lived in an accessible place, and who charged a low enough fee that Kate could afford a session. Again, the exact conjunction of factors which enabled Kate to hear this possibility calling out to her and to accept is not clear.

### **Intervention of empathetic professional, friend or family member**

Sometimes the move towards recovery is more understandable. In Christine’s case the insistence of a very empathetic psychiatrist was pivotal. Christine also talked of her good fortune in being able to stay in contact with this woman, and to continue to receive support from her over many years and in different geographical locations. Isobel talked of many bad experiences with professionals, but finally found a GP who listened and enabled Isobel to begin to experience hope of recovery, and then to act on

this hope with the support of four loyal friends. Linda's total recovery, after horrendous experiences of "*useless*" professionals, resulted from her reluctant decision to follow a friend's advice and visit a different therapist.

All these situations have an element of serendipity about them. They suggest to the friend and to the clinician that we should persevere with offers and encouragement, perhaps waiting for the moment to be right for the person to accept the suggestion or offer. Sometimes, however, the women were driven to action that was helpful to them because of their absolute refusal of an alternative.

### **Reaction to a totally unacceptable option**

There are at least two very clear examples of women feeling so strongly about one offer that they decided to take a different course themselves. For Karen the crucial decision was that she would not take Lithium. Having reached the point where this was the only remaining medication and the most likely option if she continued under professional psychiatric care, she knew she had to do something else. She decided to take better care of herself, and to never have to be hospitalised again. Hine also found that psychiatric hospital was an experience she was not prepared to repeat, and so decided to follow other paths which eventually resulted in her recovery. Hine also reacted against antidepressant medication and deliberately took it for short periods, knowing that the 'side effects' would be so bad that she would be motivated to do other things to help herself.

The psychiatric hospital situations were set within a clear historical context. In more recent times, with the closing of psychiatric hospitals, this motivation would seldom exist. This is particularly so for women experiencing depression. Another 'reactive' decision which has helped women move towards recovery and take agency has involved their realisation that they were the best parent for their children (e.g. Isobel and Katy).

### **Slowly growing awareness of possibilities**

Most of the women became aware of possibilities for recovery slowly over time. This is very clear in Chapter Nine. As was explained in the earlier section on depression as gendered, stories of living as a woman changed over historical time. New stories became available, and some of the women responded to their 'call' to education, to independence, or to their entitlement to leave a violent marriage. Making these alternative and healthy stories available is a possible role for public health and for

clinicians. Narrative therapy is one approach which incorporates an awareness of ‘the political’ and of social constructionism.

This slow process of realisation of options connects with the work of Scattolon (2003), but the women in her study mostly just ‘coped’. They found ways to stay alive and continue with their rural lives. The women in my study talked about having options. For all of them there was a range of opportunities which became available to them over time. Many lived in cities and were able to take advantage of university, women’s groups and Women’s Centres, complementary therapies including body work and homeopathy and leisure activities such as drama and art. All these options were used by some of the women.

It is possible that women could be helped by support and publicity being given to a wide range of activities and formal and informal support groups so that each woman can explore options that might work well for her. Voluntary community involvement has also worked for a number of the women at different stages of their lives (e.g. Charlotte, Naomi, Marge, Jane and Hine).

In the concluding section of this chapter I will consider some of the limitations of my project and summarise the major findings.

## ***Conclusions***

In this chapter I have drawn together some of the threads of understanding that emerged for me from the women’s stories. This understanding was greatly helped by the hours of discussion with the group of five women late in 2000. They offered insights and considered possibilities in ways that were only possible for women who had lived through the experience of depression and recovery. I had offered the group possibility only to women who had some professional training in working with people as counsellors, nurses, social workers or allied professions. I had also sought people from this group for individual interviews and they finished up making up half the group. This gives the narratives a particular flavour, and it would be interesting to repeat the project with a differently sourced group.

I have also wondered whether it would have been better to invite all the women to take part in the group and put the focus on a broader kind of shared wisdom rather than on the connection between professional training and personal experience. As it is there is a wealth of material from the eight hours of group discussion which it has not been possible to incorporate in this study.



The conclusions do, nevertheless, offer some interesting possibilities for extending our understanding of women and depression. The focus on recovery is needed, and I am pleased to have collected and valued the stories of women who stepped outside the mainstream to find ways to manage their lives with depression. Because this was my focus I found myself talking to women who were self-reflective, articulate and able to examine their own lives in considerable depth. Some of the women managed to move beyond depression altogether. Others found ways to live with depression as a ‘friend’ or regular ‘companion’ without having their lives seriously disrupted. For some women depression and recovery were relatively brief interludes in their lives; for others the journey started before they were born, and continues on a daily basis. Yet others do not have any confidence that depression will not come into their lives again, but they feel they have learned ways to limit the potential disruption.

The final chapter of the thesis is a brief Postscript which I have called ‘So What? In it I reflect upon my own journey with this project and review the possible outcomes for myself, for clinicians, for policy-makers and especially for women who find their lives disrupted by depression.

## Chapter Twelve: So What? A Postscript

In this final chapter I look back over the story which resulted in the production of this thesis. I also look ahead to what the sequel might be; what I hope it will be. I do this in a contextualised way. I start with my own journey, reflect on the place of the eighteen women in this story and then consider the wider landscape. I end the thesis with a part of the narrative of Kate, the youngest of the participating women.

### ***My journey as researcher and author***

The process of planning, carrying out and writing up this research has taken place over a period of eight years. There is a personal story to be told in another place, but here I wish to add a short reflection on the inter-twining stories of my own ‘quirky’ self. I was drawn to do this work from my connected lives as woman, counsellor, and university staff member. Had I been born in 1984 instead of 1944 I would possibly have studied for a PhD in my twenties rather than my fifties. Had I been born in 1844 or 1884 I might have had a life much more like that of Gilman’s heroine referred to on the opening page of this thesis. Then I would never have had the opportunity to research and to write. I have been lucky enough to find the opportunity to seek out women who had stories they wanted to tell, and to be allowed to engage with the women and their narratives.

The engagement has been emotional as well as intellectual; it has also, I hope, been in some way political. The women told their stories because they wanted to make it easier for other women whose lives were disrupted by depression. I feel very humble in my role as teller and translator of these stories. In my position as a university student I have been able to read lots of other stories about women and depression, and to try to situate the stories of these eighteen women alongside stories from across the world.

### ***The Wishes of Eighteen Women***

All the women who took part in this research hoped that it would benefit other women. The most likely way for this to happen will be if we succeed in carrying out a project proposed by the five women in the group. At the last meeting the women discussed how research might come to make a difference. We all agreed that a PhD thesis has a very small and select audience, whilst it may reach some professionals and clinicians it is unlikely to be read by a wide cross-section of women experiencing depression. The

women hope that when this thesis is complete we can all meet together and work as equals to produce a book that can be accessible to women from across the community. I sincerely hope and intend that this plan will come to fruition.

In the meantime it has been important to talk about the women's stories in a number of venues, including conferences, women's breakfasts and meetings of clinicians, including counsellors, nurses, doctors and community mental health workers. Within Aotearoa New Zealand the voices of consumers of the mental health services are being heard with increasing regularity. In the last month I have had my attention drawn to a position being advertised locally seeking a person who has lived with mental illness to work within the hospital based mental health services. This is no longer an extremely unusual thing in this country.

### ***The Wider Landscape***

The Mental Health Commission in Aotearoa New Zealand is committed to the promotion of recovery based services, and to consultation with people who have lived with mental health problems. They have supported research which values the experiences of people who are 'experts' on themselves. I hope that this piece of research will contribute to the growth of understanding of the complexity and the contextualised nature of various kinds of distress but especially the distress of women experiencing 'depression'. In doing so they could come to make accessible and affordable a wider range of responses to 'depression' than the professional treatments which are currently part of the dominant story of recovery.

### ***Final Words from Kate***

*The normal state is feeling clear, and feeling positive, and being happy. I mean, not like, I mean, I'd love to be joyously happy. I can't say that I'm joyously happy. But I have moments of joy. And, and on a day to day level, I'm very happy. And, that is just, I haven't been very happy, for it feels like my entire life. Ever since I was ten. And --- And I look back on my twenties and I think, Ohh, I would love to have known what I know now, then. Because I would have had a ball. I mean I had a great time. I had a great time. And I wouldn't be the person that I am now if I hadn't done those things. But, I would've just --- I would have relished the whole thing, so much more. Even down to clothes. I always used to wear black. Always wore black. Because I couldn't cope with colours. I couldn't mix colours, I didn't want to wear colours. But. Yeah. The first thing we did when we moved in here was cream on cream. I thought right, oh well orange living room, got turquoise in there. The bedroom will be yellow. You know. And I, and it's not orange*

*enough, but I'm just too lazy to re-paint it basically. You know it would need --- it will need re-doing eventually, and then it might be tangerine, but , umm, yeah it wasn't till I came here, that I suddenly thought Ooo, I could experiment you know, and I found one, like now, I don't actually even pick out black. I'll look at a red dress and a black dress, and I'll think ooo , I'll have the red one. Whereas I always used to buy everything in black. Because not only did I want to wear it, but it looked nicer.*

*Now I can enjoy colours. Yeah, and patterns and ummm, I think, I think that reflects your state of mind. There's that whole kind of, you know, teenagers wear black. Well that's because they can't cope with anything else. Whereas my best friend L was always like an explosion in a paint factory. (laughs) You, know, just like everything --- and it would always look fantastic. And I'd think "How do you do that? I can't do that. I can't do even --- Nooo, I can't do that. " But I used to when I was about 13 . At the very beginning. I did. But it only took like a couple of little mistakes, or a couple of odd glances in the street. And I'd "Oh no, I can't do that".*

Now when I look at Kate, her clothes and her house look like "an explosion in a paint factory". She talked with wistfulness, wisdom and elation about the thirty-two years of her life, half of which were spent in the fog of depression. She is confident that she has found the right formula for her. She can now enjoy the colour in her life, and her narrative offers hope to other women who want to find a way beyond their lives being seriously disrupted by depression.

## REFERENCES

- Abramson, L., Metalsky, G., & Alloy, L. (1989). Hopelessness depression: A theory-based subtype of depression. *Psychological Review*, 96, 358-372.
- Albright, J. S., & Henderson, M. C. (1995). How real is depressive realism? A question of scales and standards. *Cognitive Therapy and Research*, 19(5), 589-609.
- Allen, R. E. (Ed.). (1990). *The concise Oxford dictionary of current English* (8th ed.). Oxford: Clarendon Press.
- Alonso, J., Angermeyer, M. C., Bernert, S., Bruffaerts, R., Brugha, T. S., Bryson, H., et al. (2004). Prevalence of mental disorder in Europe: Results from the European study of the epidemiology of mental disorders. *Acta Psychiatrica Scandinavica*, 109 (Suppl. 420), 21-27.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders: DSM-IV-TR* (4th ed.). Washington, DC: American Psychiatric Association.
- Anderson, J. M. (2004). Lessons from a postcolonial-feminist perspective: Suffering and a path to healing. *Nursing Inquiry*, 11(4), 238-246.
- Anderson, L., Lewis, G., & Araya, R. (2005). Self-help books for depression: How can practitioners and patients make the right choice? *Journal of General Practice*, 55, 387 - 392.
- Atkinson, R. (2002). The life story interview. In J. F. Gubrium & J. A. Holstein (Eds.), *Handbook of interview research: Context and method* (pp. 121- 140). Thousand Oaks: Sage.
- Avery, L. (1998). A feminist perspective on group work with severely mentally ill women. *Woman and Therapy*, 21(4), 1-10.
- Avis, N. (2003). Depression during the menopausal transition. *Psychology of Women Quarterly*, 27, 91-100.
- Baker, M. (2002). Child poverty, maternal health and social benefits. *Current Sociology*, 50(6), 823-838.
- Barnes, G. G. (2004). *Family therapy in changing times* (2nd ed.). Basingstoke, Hampshire: Palgrave MacMillan.
- Barney, L. J., Griffiths, K. M., Jorm, A. F., & Christensen, H. (2005). Stigma about depression and its impact on help-seeking intentions. *Australian and New Zealand Journal of Psychiatry*, 40, 51-54.
- Beck, A. (1993). Cognitive therapy: Past, present, and future. *Journal of Consulting and Clinical Psychology*, 61(2), 194-198.
- Beck, A., Steer, R. A., Ball, R., & Ranieri, W. F. (1996). Comparison of Beck Depression Inventories - 1A and - II in psychiatric outpatients. *Journal of Personality*, 67(3), 588-597.
- Beck, C. A., Williams, J. V. A., Wang, J. L., Kassam, A., El-Guebaly, N., Currie, S., et al. (2005). Psychotropic medication use in Canada. *Canadian Journal of Psychiatry*, 50(10), 605-613.
- Belle, D., & Doucet, J. (2003). Poverty, inequality, and discrimination as sources of depression among U.S. women. *Psychology of Women Quarterly*, 27, 101-113.
- Bendall, S. (1994). *A feminist poststructuralist analysis of women's experiences of their menstrual cycles*. Unpublished Masters Thesis, University of Auckland, Auckland, New Zealand.
- Berger, B. G., & Owen, D. R. (1992). Mood alteration with yoga and swimming: Aerobic exercise may not be necessary. *Perceptual and Motor Skills*, 75, 1331-1343.

- Bergeron, E., Poirier, L.-R., Fournier, L., Roberge, P., & Barrette, G. (2005). Determinants of service use among young Canadians with mental disorders. *Canadian Journal of Psychiatry*, 50(10), 629-636.
- Bhui, K., & Fletcher, A. (2000). Common mood and anxiety states: Gender differences in the protective effect of physical activity. *Social Psychiatry and Psychiatric Epidemiology*, 35, 28-35.
- Bird, J. (2000). *The heart's narrative: Therapy and navigating life's contradictions*. Auckland: Edge Press.
- Bird, J. (2004). *Talk that sings: Therapy in a new linguistic key*. Auckland: Edge Press.
- Bodnar, L. M., & Wisner, K. L. (2005). Nutrition and depression: Implications for improving mental health among childbearing-aged women. *Biological Psychiatry*, 58, 679-685.
- Bourdieu, P. (1998). *Practical reason: On the theory of action* (P. Press, Trans.). Cambridge, UK: Polity Press.
- Broverman, I. K., Broverman, D. M., Clarkson, F. E., Rosencrantz, P. S., & Vogel, S. R. (1970). Sex-role stereotypes and clinical judgements of mental health. *Journal of Counselling and Clinical Psychology*, 34(1), 1-7.
- Brown, G. W., Adler, Z., & Bifulco, A. (1988). Life events, difficulties and recovery from chronic depression. *British Journal of Psychiatry*, 152, 487-498.
- Brown, G. W., & Harris, T. (1978). *Social origins of depression: A study of psychiatric disorder in women*. London: Tavistock.
- Brown, G. W., Harris, T., & Hepworth, C. (1994). Life events and endogenous depression: A puzzle reexamined. *Archives of General Psychiatry*, 51, 525-534.
- Brown, G. W., Lemyre, L., & Bifulco, A. (1992). Social factors and recovery from anxiety and depressive disorders: A test of specificity. *British Journal of Psychiatry*, 161, 44-54.
- Brown, G. W., & Moran, P. (1994). Clinical and psychosocial origins of chronic depressive episodes. I: A community survey. *British Journal of Psychiatry*, 165, 447-456.
- Brown, L. S. (2000). Discomforts of the powerless: Feminist constructions of distress. In R. A. Neimeyer (Ed.), *Constructions of disorder: Meaning-making frameworks for psychotherapy* (pp. 287-308). Washington DC: American Psychological Association.
- Bruner, J. (1987). Life as narrative. *Social Research*, 54(1), 11-32.
- Bruner, J. (1990). *Acts of meaning*. Cambridge: Harvard University Press.
- Bruner, J. (2002). *Making stories: Law, literature, life*. Cambridge, MA: Harvard University Press.
- Burman, E. (1994). Interviewing. In P. Banister, E. Burman, I. Parker, M. Taylor & C. Tindall (Eds.), *Qualitative methods in psychology: A research guide* (pp. 49-71). Buckingham, Philadelphia: Open University Press.
- Burr, V. (1995). *An Introduction to social constructionism*. London: Routledge.
- Busfield, J. (1996). *Men, women and madness*. London: Macmillan Press Ltd.
- Cairns, T. (1996). *Hui Whakapiripiri: A hui to discuss strategic directions for Maori health research*. Wellington: Te Ropu Rangahau Hauora a Eru Pomare (Eru Pomare Maori Health Research Centre), University of Otago, Wellington School of Medicine.
- Caspi, A., Sugden, K., Moffitt, T., Taylor, A., Craig, I. W., Harrington, H., et al. (2003). Influence of life stress on depression: Moderation by a polymorphism in the 5-HTT gene. *Science*, 301, 386-389.

- Ceci, C. (2003). Midnight reckonings: On a question of knowledge and nursing. *Nursing Philosophy*, 4, 61-76.
- Cemalcilar, Z., Canbeyli, R., & Sunar, D. (2003). Learned helplessness, therapy, and personality traits: An experimental study. *The Journal of Social Psychology*, 143(1), 65-81.
- Chananie, R. A. (2005). Psychopharmaceutical advertising strategies: Empowerment in a pill? *Sociological Spectrum*, 25, 487-518.
- Chesler, P. (1972). *Women and madness*. Garden City, N.Y.: Doubleday.
- Chilvers, C., Dewey, R., Churchill, R., Fielding, K., Gretton, V., Miller, P., et al. (2001). Antidepressant drugs and generic counselling for treatment of major depression in primary care: Randomised trial with patient preference arms. *BMJ*, 332, 772-779.
- Chinman, M., Kloos, B., O'Connell, M., & Davidson, L. (2002). Service providers' views of psychiatric mutual support groups. *Journal of Community Psychology*, 30(4), 349 - 366.
- Chrisler, J. C., & Lamont, J. M. (2002). Can exercise contribute to the goals of feminist therapy? *Women and Therapy*, 25(2), 9-18.
- Christians, C. G. (2003). Ethics and politics in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The landscape of qualitative research: Theories and issues* (2nd ed., pp. 208-243). Thousand Oaks: Sage.
- Clarke, D., & Jensen, M. A. (1997). The effects of social support, life events, and demographic factors on depression among Maori and Europeans in New Zealand rural, town, and urban environments. *Journal of Community Psychology*, 25(4), 303-323.
- Coker, A. L., Smith, P. H., Thompson, M. P., McKeown, R. E., Bethea, L., & Davis, K., E. (2002). Social support protects against the negative effects of partner violence on mental health. *Journal of Women's Health and Gender-Based Medicine*, 11(5), 465-476.
- Collinge, W., Wentworth, R., & Sabo, S. (2005). Integrating complementary therapies into community mental health practice: An exploration. *The Journal of Alternative and Complementary Medicine*, 11(3), 569-574.
- Cooper-Patrick, L., Powe, N. R., Jenckes, M. W., Gonzales, J. J., Levine, D. M., & Ford, D. E. (1997). Identification of patient attitudes and preferences regarding treatment of depression. *Journal of General Internal Medicine*, 12, 431-438.
- Coyne, I. T. (1996). Sampling in qualitative research. Purposeful and theoretical sampling; Merging or clear boundaries? *Journal of Advanced Nursing*, 26, 623-630.
- Crossley, M. (2000). *Introducing narrative psychology: Self, trauma and the construction of meaning*. Buckingham, Philadelphia: Open University Press.
- Crowe, M. (2002). Reflexivity and detachment: A discursive approach to women's depression. *Nursing Inquiry*, 9(2), 126-132.
- Davies, B. (1991). The concept of agency: A feminist poststructuralist analysis. *Social Analysis*, 30, 42-53.
- Davies, B., Browne, J., Gannon, S., Hopkins, L., McCann, H., & Wihlborg, M. (2006). Constituting the feminist subject in poststructuralist discourse. *Feminism and Psychology*, 16(1), 87-103.
- Demyttenaere, K. (2001). Compliance and acceptance in antidepressant treatment. *International Journal of Psychiatry in Clinical Practice*, 5(Supplement 1), S29-S35.

- Dickinson, L. M., de Gruy, F. V. I., Dickinson, W. P., & Candib, L. M. (1999). Health-related quality of life and symptom profiles of female survivors of sexual abuse in primary care. *Archives of Family Medicine*, 8, 35-43.
- Dimeo, F., Bauer, M., Varahram, I., Proest, G., & Halter, U. (2001). Benefits of aerobic exercise in patients with major depression: A pilot study. *British Journal of Sports Medicine*, 35, 114-117.
- Draucker, C. B., & Hessmiller, J. M. (2002). Telling stories of suffering and survival: Women and violence. In N. Diekelmann (Ed.), *First, do no harm: Power, oppression, and violence in healthcare* (pp. 204 - 250). Madison: University of Wisconsin Press.
- Drewery, W., Winslade, J., & Monk, G. (2000). Resisting the dominating story: Toward a deeper understanding of narrative therapy. In R. A. Neimeyer & J. D. Raskin (Eds.), *Constructions of disorder: Meaning-making frameworks for psychotherapy* (pp. 243-263). Washington DC: American Psychological Association.
- Duffy, M., Gillig, S. E., Tureen, R. M., & Ybarra, M. A. (2002). A critical look at the DSM-IV. *The Journal of Individual Psychology*, 58(4), 363-373.
- Durie, M. (1998a). Mental health and Maori development. *Australian and New Zealand Journal of Psychiatry*, 33, 5-12.
- Durie, M. (1998b). *Whaiora: Maori health development* (2nd ed.). Melbourne: Oxford University Press.
- Durie, M. (2001). *Mauri Ora: The dynamics of Maori health*. Melbourne: Oxford University Press.
- Durie, M. (2003). *Nga Kahui Pou launching Maori futures*. Wellington: Huia Publishers.
- Edwards, R. (1993). An education in interviewing: Placing the researcher and the research. In C. M. Renzetti & R. M. Lee (Eds.), *Researching sensitive topics* (pp. 181-196). Newbury Park: Sage.
- Edwards, R., & Mauthner, M. (2002). Ethics and feminist research: Theory and practice. In M. Mauthner, M. Birch, J. Jessop & T. Miller (Eds.), *Ethics in qualitative research* (pp. 14-31). London: Sage.
- Eli Lilly & Company (NZ) Ltd. (1996). *Depression: The road to recovery*. Auckland: Eli Lilly & Company (NZ) Ltd.
- Elliott, J. (2005). *Using narrative in social research: Qualitative and quantitative approaches*. London: Sage.
- Epston, D., & White, M. (1990). *Narrative means to therapeutic ends*. New York: W.W.Norton.
- Ernst, E. (2003). Complementary medicine: Where is the evidence? *The Journal of Family Practice*, 52(8), 630-634.
- Ernst, E., Rand, J. L., & Stevinson, C. (1998). Complementary therapies for depression: An overview. *Archives of General Psychiatry*, 55, 1026-1032.
- Ernst, E., & Schmidt, K. (2004). 'Alternative' cures for depression - how safe are web sites? *Psychiatry Research*, 129, 297-301.
- Esler, I. (1988). A cybernetic approach to women and depression. *Family Therapy Case Studies*, 3, 47-54.
- Fava, G. A., & Ruini, C. (2005). What is the optimal treatment of mood and anxiety disorders? *Clinical Psychology: Science and Practice*, 12(1), 92-96.
- Fee, D. (2000). The project of pathology: Reflexivity and depression in Elizabeth Wurzel's Prozac Nation. In D. Fee (Ed.), *Pathology and the Postmodern: Mental illness as discourse and experience* (pp. 74-99). London: Sage.



- Fergusson, D. M., & Horwood, L. J. (2001). The Christchurch health and development study: Review of findings on child and adolescent mental health. *Australian and New Zealand Journal of Psychiatry*, 35, 287-296.
- Fine, M. (1994). Working the hyphens: Reinventing the self and other in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 70 - 82). Thousand Oaks: Sage.
- Flax, J. (1993). *Disputed subjects: Essays on psychoanalysis, politics and philosophy*. New York: Routledge.
- Fontana, A., & Frey, J. H. (1994). Interviewing: The art of science. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 361-376). Thousand Oaks: Sage.
- Fox, N. J. (1997). Is there life after Foucault? Texts, frames and *differends*. In A. Peterson & R. Bunton (Eds.), *Foucault, health and medicine* (pp. 31-50). London: Routledge.
- Frank, A. W. (1992). The pedagogy of suffering: Moral dimensions of psychological therapy and research with the ill. *Theory and Psychology*, 2(4), 467-485.
- Frank, A. W. (1995). *The wounded storyteller: Body, illness and ethics*. Chicago: University of Chicago Press.
- Frank, A. W. (2002a). "How can they act like that?": Clinicians and patients as characters in each other's stories. *Hastings Center Report*, 32(6), 14-22.
- Frank, A. W. (2002b). Why study people's stories? The dialogical ethics of narrative analysis. *International Journal of Qualitative Methods*, 1(1), 1-20.
- Frank, A. W., & Jones, T. (2003). Bioethics and the later Foucault. *Journal of Medical Humanities*, 24(3/4), 179-186.
- Frankenberger, K. A., Frankenberger, W. R., Peden, B. F., Hunt, H. L., Raschick, C. M., Steller, E. G., et al. (2004). Effects of information on college students' perceptions of antidepressant medication. *Journal of American College Health*, 53(1), 35 - 40.
- Gabriel, Y. (2004). The voice of experience and the voice of the expert - can they speak to each other? In B. Hurwitz, T. Greenhalgh & V. Skultans (Eds.), *Narrative research in health and illness* (pp. 168-185). Oxford: Blackwell.
- Gammell, D. J., & Stoppard, J. M. (1999). Women's experiences of treatment of depression: Medicalization or empowerment? *Canadian Psychology*, 40(2), 112-128.
- Garfield, S., Francis, S.-A., & Smith, F. J. (2004). Building concordant relationships with patients starting antidepressant medication. *Patient Education and Counselling*, 55, 241-246.
- Gattuso, S., Fullagar, S., & Young, I. (2005). Speaking of women's 'nameless misery': The everyday construction of depression in Australian women's magazines. *Social Science and Medicine*, 61, 1640-1648.
- Gergen, K. (1998). The ordinary, the original, and the believable in psychology's reconstruction of the person. In B. M. Bayer & J. Shotter (Eds.), *Reconstructing the psychological subject: Bodies, practices and technologies* (pp. 111-125). London: Sage.
- Gergen, K. (2000). The self: Transfiguration by technology. In D. Fee (Ed.), *Pathology and the postmodern: Mental illness as discourse and experience* (pp. 100-115). London: Sage.

- Gergen, K., & McNamee, S. (2002). From disordered discourse to transformative dialogue. In R. A. Neimeyer & J. D. Raskin (Eds.), *Constructions of disorder: Meaning-making frameworks for psychotherapy* (pp. 333-349). Washington, DC: American Psychological Association.
- Gergen, M. M., & Gergen, K. (2003). Qualitative inquiry: Tensions and transformations. In N. K. Denzin & Y. S. Lincoln (Eds.), *The landscape of qualitative research: Theories and issues* (2nd ed., pp. 575-610). Thousand Oaks: Sage.
- Gilliam, C. M., & Cottone, R. R. (2005). Couple or individual therapy for the treatment of depression? An update of the empirical literature. *The American Journal of Family Therapy*, 33, 265-272.
- Glowinski, A., Madden, P., Bucholz, K., Lynskey, M., & Heath, A. (2003). Genetic epidemiology of self-reported lifetime DSM-IV major depressive disorder in a population-based twin sample of female adolescents. *Journal of Child Psychology and Psychiatry*, 44(7), 988-996.
- Golding, J. M. (1999). Intimate partner violence as a risk factor for mental disorders: A meta-analysis. *Journal of Family Violence*, 14, 99-132.
- Goldsack, S., Reet, M. S., Lapsley, H., & Gingell, M. (2005). *Experiencing a recovery-oriented acute mental health service: Home based treatment from the perspectives of service users, their families and mental health professionals*. Wellington, New Zealand: Mental Health Commission.
- Grbich, C. (1999). *Qualitative research in health: An introduction*. St Leonards, Sydney: Allen and Unwin.
- Greenspan, H. (2003). Listening to holocaust survivors: Interpreting a repeated story. In R. Josselson, A. Lieblich & D. P. McAdams (Eds.), *Up close and personal: The teaching and learning of narrative research* (pp. 101-111). Washington: American Psychological Association.
- Gregg, G. S. (2006). The raw and the bland: A structural model of narrative identity. In D. P. McAdams, R. Josselson & A. Lieblich (Eds.), *Identity and story: Creating self in narrative* (pp. 63-87). Washington, DC: American Psychological Association.
- Grof, S., & Grof, C. (Eds.). (1989). *Spiritual emergency: When personal transformation becomes a crisis*. Los Angeles: St Martins Press.
- Gubrium, J. F., & Holstein, J. A. (2002). From the individual interview to the interview society. In J. F. Gubrium & J. A. Holstein (Eds.), *Handbook of interview research: Context and method* (pp. 3-32). Thousand Oaks: Sage.
- Haines, H. (1987). *Mental health for women*. Auckland: Reed Methuen.
- Harris, T. (2003). Depression in women and its sequelae. *Journal of Psychosomatic Research*, 54, 103-112.
- Hawes, S. E. (1998). Positioning a dialogic reflexivity in the practice of feminist supervision. In B. M. Bayer & J. Shotter (Eds.), *Reconstructing the psychological subject: Bodies, practices and technologies* (pp. 94-110). London: Sage.
- Hawkins, M. T., & Miller, R. j. (2003). Cognitive vulnerability and resilience to depressed mood. *Australian Journal of Psychology*, 55(3), 176-183.
- Headspace.org. (2007). Maori Mental Health. . Retrieved February 17, 2007 from <http://www.headspace.org.nz/maori-mental-health.htm>

- Heilemann, M. V., Frutos, L., Lee, K. A., & Kury, F. S. (2004). Protective strength factors, resources and risks in relation to depressive symptoms among childbearing women of Mexican descent. *Health Care for Women International*, 25(1), 88-106.
- Henkel, V., Bussfeld, P., Moller, H., & Hegerl, U. (2002). Cognitive-behavioural theories of helplessness/hopelessness: Valid models of depression? *European Archives of Psychiatry and Clinical Neuroscience*, 252, 240-249.
- Henriques, J., Hollway, W., Urwin, C., Venn, C., & Walkerdine, V. (1984). *Changing the subject: Psychology, social regulation and subjectivity*. London: Methuen.
- Hesook, S. K. (1999). Types of Research: Narrative Analysis. In J. J. Fitzpatrick (Ed.), *Nursing Research Digest* (pp. 36-38). New York: Springer.
- Hewitt, J. P., Fraser, M. R., & Berger, L. (2000). Is it me or is it Prozac? Antidepressants and the construction of the self. In D. Fee (Ed.), *Pathology and the postmodern: Mental illness as discourse and experience* (pp. 163-185). London: Sage.
- Hight, N., & Drummond, P. (2004). A comparative evaluation of community treatments for post-partum depression: Implications for treatment and management practices. *Australian and New Zealand Journal of Psychiatry*, 38, 212-218.
- Hollon, S. D., Shelton, R. C., & Davis, D. D. (1990). Cognitive therapy for depression: Conceptual issues and clinical efficacy. *Journal of Consulting and Clinical Psychology*, 61, 270-275.
- Hollway, W., & Jefferson, T. (2000). *Doing qualitative research differently: Free association, narrative and the interview method*. London: Sage.
- Hoyt, D. R., Conger, R. D., Valde, J. G., & Weihs, K. (1997). Psychological distress and help seeking in rural America. *American Journal of Community Psychology*, 25, 449-470.
- Hurst, S. A. (2003). Legacy of betrayal: A theory of demoralization from the perspective of women who have been depressed. In J. M. Stoppard & L. M. McMullen (Eds.), *Situating sadness: Women and depression in social context* (pp. 139-161). New York: New York University Press.
- Hurwitz, B., Greenhalgh, T., & Skultans, V. (Eds.). (2004). *Narrative research in health and illness*. Oxford: Blackwell Publishing.
- Hyman, P. (1994). *Women and economics: A New Zealand feminist perspective*. Wellington: Bridget Williams Books.
- Jack, D. (1991). *Silencing the self: Women and depression*. New York: Harper Perennial.
- Jack, D. (1999). *Behind the mask: Destruction and creativity in women's aggression*. Cambridge, Massachusetts: Harvard University Press.
- Jack, D. (2001). Understanding women's anger: A description of relational patterns. *Health Care for Women International*, 22, 385-400.
- Jack, D. (2003). The anger of hope and the anger of despair: How anger relates to women's depression. In J. M. Stoppard & L. M. McMullen (Eds.), *Situating sadness: Women and depression in context* (pp. 62-87). New York: New York University Press.
- Jack, D., & Dill, D. (1992). The Silencing of the Self Scale: Schemas of intimacy associated with depression in women. *Psychology of Women Quarterly*, 16, 97-106.
- Joiner, T. E., & Tickle, J. J. (1998). Exercise and depressive symptoms: What is the nature of their interactions? *Journal of Occupational Rehabilitation*, 8, 191-198.

- Jones, A. (1997). Teaching poststructuralist theory in education: Student resistances. *Gender and Education*, 9, 261-269.
- Jones, S. (2002). (Re)Writing the word: Methodological strategies and issues in qualitative research. *Journal of College Student Development*, 43(4), 461 - 473.
- Jorm, A. F., & Griffiths, K. M. (2005). Population promotion of informal self-help strategies for early intervention against depression and anxiety. *Psychological Medicine*, 36, 3 - 6.
- Joyce, P. R., Mulder, R. T., Luty, S. E., McKenzie, J. M., & Rae, A. M. (2003). A differential response to nortriptyline and fluoxetine in melancholic depression: The importance of age and gender. *Acta Psychiatrica Scandinavica*, 108, 20-23.
- Joyce, P. R., Mulder, R. T., Luty, S. E., Sullivan, P. F., McKenzie, J. M., Abbott, R. M., et al. (2002). Patterns and predictors of remission, response and recovery in major depression treated with fluoxetine or nortriptyline. *Australian and New Zealand Journal of Psychiatry*, 36, 384 - 391.
- Kaslow, N. J., Thompson, M. P., Meadows, L. A., Jacobs, D., Chance, S., Gibb, B., et al. (1998). Factors that mediate and moderate the link between partner abuse and suicidal behaviour in African American women. *Journal of Consulting and Clinical Psychology*, 66(3), 533-540.
- Kendall, M., & Murray, S. (2004). Poems from the heart: Living with heart failure. In B. Hurwitz, T. Greenhalgh & V. Skultans (Eds.), *Narrative research in health and illness* (pp. 52-72). Oxford: Blackwell Publishing.
- Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., Rush, J. A., et al. (2003). The epidemiology of major depressive disorder: Results from the national comorbidity survey replication (NCS-R). *JAMA*, 289(23), 3095-3105.
- Kincheloe, J., & McLaren, P. (1994). Rethinking critical theory and qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 138-157). Thousand Oaks, CA: Sage.
- Kirkman, M. (1999, 6-10 July, 1999). *Revising the plot: Autobiographical narratives after infertility*. Paper presented at the The International conference of the Association for Qualitative Research: "Issues of rigour in qualitative research", Melbourne, Australia.
- Kitzinger, C., & Wilkinson, S. (1996). Theorizing representing the other. In S. Wilkinson & C. Kitzinger (Eds.), *Representing the other: A feminism and psychology reader* (pp. 1-32). London: Sage.
- Koopowitz, L. F., Chur-Hansen, A., Reid, S., & Blashki, M. (2003). The subjective experience of patients who received electroconvulsive therapy. *Australian and New Zealand Journal of Psychiatry*, 37, 49-54.
- Koss, M. P., Herrera, V. M., & Lichter, E. L. (2003). Depression and PTSD in survivors of male violence: Research and training initiatives to facilitate recovery. *Psychology of Women Quarterly*, 27, 130-142.
- Kramer, P. D. (1994). *Listening to Prozac*. London: Fourth Estate.
- Laitinen, I., Ettorre, E., & Sutton, C. (2006). Empowering depressed women: Changes in 'individual' and 'social' feelings in guided self-help groups in Finland. *European Journal of Psychotherapy, Counselling and Health*, 305 - 320.
- Lapsley, H., Nikora, L. W., & Black, R. (2002). *"Kia Mauri Tau": Narratives of recovery from disabling mental health problems. Report of the University of Waikato Mental Health Narratives Project*. Wellington, New Zealand: Mental Health Commission.
- Lather, P. A. (1991). *Getting smart: Feminist research and pedagogy with/in the postmodern*. New York: Routledge.

- Leibrich, J. (Ed.). (1999). *A gift of stories*. Dunedin: Univeristy of Otago Press/ Mental Health Commission.
- Lerman, H. (1986). *A mote in Freud's eye: From psychoanalysis to the psychology of women*. New York: Springer.
- Lerman, H. (1996). *Pigeonholing women's misery: A history and critical analysis of the psychodiagnosis of women in the twentieth century*. New York.
- Lesch, K. P. (2004). Gene-environment interaction and the genetics of depression. *Journal of Psychiatry and Neuroscience*, 29(3), 174-184.
- Levitt, H., Korman, Y., & Angus, L. (2000). A metaphor analysis in treatments of depression: Metaphor as a marker of change. *Counselling Psychology Quarterly*, 13(1), 23 - 35.
- Lieblich, A., Tuval-Mashiach, R., & Zilber, T. (1998). *Narrative research: Reading, analysis, and interpretation* (Vol. 47). Thousand Oaks: Sage.
- MacQueen, G., & Chokka, P. (2004). Special issues in the management of depression in women. *Canadian Journal of Psychiatry*, 49(Supplement 1), 27S-40S.
- Madriz, E. (2003). Focus groups in feminist research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Collecting and interpreting qualitative materials* (pp. 363-389). Thousands Oaks: Sage.
- Mahoney, M. J. (1991). *Human change processes: The scientific foundations of psychotherapy*. New York: Basic Books.
- Manning, P. K., & Cullum-Swan, B. (1994). Narrative, content and semiotic analysis. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 463-485). Thousand Oaks, CA: Sage.
- Marshall, S. (2005). *What it's like being us: Stories of young New Zealanders who experience difficulty learning*. Unpublished Thesis for Master of Health Science Degree, Auckland University of Technology, Auckland.
- Martin, E. (1992). *The woman in the body: A cultural analysis of reproduction*. Boston: Beacon Press.
- Mason, J. (2002). Qualitative interviewing: Asking, listening and interpreting. In T. May (Ed.), *Qualitative research in action* (pp. 225-241). London: Sage.
- Mauthner, N. S. (2003). "Imprisoned in my own prison"; A relational understanding of Sonya's story of postpartum depression. In J. M. Stoppard & L. M. McMullen (Eds.), *Situating sadness: Women and depression in social context* (pp. 88-112). New York: New York University Press.
- McAdams, D. P. (1993). *The stories we live by: Personal myths and the making of the self*. New York: Morrow.
- McAdams, D. P., Josselson, R., & Lieblich, A. (Eds.). (2006). *Identity and story: Creating self in narrative*. Washington DC: American Psychological Association.
- McGrath, E., Keita, G. P., Strickland, B. R., & Russo, N. F. (Eds.). (1990). *Women and depression: Risk factors and treatment issues: Final report of the American Psychological Association's National Task Force on Women and Depression*. Washington DC: American Psychological Association.
- McMullen, L. M. (2003). "Depressed" Women's constructions of the deficient self. In J. M. Stoppard & L. M. McMullen (Eds.), *Situating sadness: Women and depression in social context* (pp. 17-38). New York: New York University Press.
- McMullen, L. M., & Stoppard, J. M. (2003). Conclusion. In J. M. Stoppard & L. M. McMullen (Eds.), *Situating sadness: Women and depression in social context* (pp. 207 - 215). New York: New York University Press.

- McNair, B. G., Highet, N. J., Hickie, I. B., & Davenport, T. A. (2002). Exploring the perspectives of people whose lives have been affected by depression. *Medical Journal of Australia*, 176, S69-S76.
- McPherson, S., Cairns, P., Carlyle, J., Shapiro, D. A., Richardson, P., & Taylor, D. (2005). The effectiveness of psychological treatments for treatment-resistant depression: a systematic review. *Acta Psychiatrica Scandinavica*, 111, 331-340.
- McWha, J. L., Pachana, N. A., & Alpass, F. (2003). Exploring the therapeutic environment for older women with late-life depression: An examination of the benefits of an activity group for older people suffering from depression. *Australian Occupational Therapy Journal*, 50, 158 - 169.
- Members of the bi-polar support group North Shore and Whangaparaoa support group for mental health. (2000). *Walk with us: A collection of poems and stories from the heart. Shared experiences concerning mental health*. Auckland: Assembly Line.
- Ministry of Health, N. Z. (2004). *Use of electroconvulsive therapy (ECT) in New Zealand: A review of efficacy, safety, and regulatory controls*. Wellington: Ministry of Health.
- Ministry of Health, N. Z. (2007). Depression. Retrieved 19 February, 2007 from <http://www.depression.org.nz/>
- Mishler, E. G. (1986). *Research interviewing: Context and narrative*. Cambridge: Harvard University Press.
- Monk, G. (1997). How narrative therapy works. In G. Monk, J. Winslade, K. Crockett & D. Epston (Eds.), *Narrative therapy in practice: The archaeology of hope* (pp. 3-31). San Francisco: Jossey-Bass.
- Monkul, E. S., Malhi, G. S., & Soares, J. C. (2003). Mood disorders - review of structural MRI studies. *Acta Neuropsychiatrica*, 15, 368 - 380.
- Morgan, D. L. (1996). Focus groups. *Annual Review of Sociology*, 22, 129-152.
- Morgan, D. L. (2002). Focus group interviewing. In J. F. Gubrium & J. A. Holstein (Eds.), *Handbook of interview research: Context and method* (pp. 141-159). Thousand Oaks: Sage.
- Morse, J. M. (1994). Designing funded qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 220-235). Thousand Oaks: Sage.
- Morse, J. M. (2002). Interviewing the ill. In J. F. Gubrium & J. A. Holstein (Eds.), *Handbook of interview research: Context and method* (pp. 317 - 328). Thousand Oaks: Sage.
- Moss, G. (2004). Provisions of trustworthiness in critical narrative research: Bridging intersubjectivity and fidelity. *The Qualitative Report*, 9(2), 359-374.
- National Health Committee. (1996). *Guidelines for the treatment and management of depression by primary healthcare professionals*. Wellington: National Advisory Committee on Health and Disability.
- Neimeyer, R. A. (2000). Narrative disruptions in the construction of the self. In R. A. Neimeyer & J. D. Raskin (Eds.), *Constructions of disorder: Meaning-making frameworks for psychotherapy* (pp. 207-242). Washington DC: American Psychological Association.
- Nicolson, P. (2003). Postpartum depression: Women's accounts of loss and change. In J. M. Stoppard & L. M. McMullen (Eds.), *Situating sadness: Women and depression in social context* (pp. 113-138). New York: New York University Press.

- Nolen-Hoeksema, S. (1990). *Sex differences in depression*. California: Stanford University Press.
- Nolen-Hoeksema, S., & Keita, G. P. (2003). Women and depression: Introduction. *Psychology of Women Quarterly*, 27, 89-90.
- O'Grady, H. (2005). *Woman's relationship with herself: Gender, Foucault and therapy*. London: Routledge.
- O'Hagan, M. (2001). *Recovery competencies for New Zealand mental health workers*. Wellington: Mental Health Commission.
- Pampallona, S., Bollini, P., Tibaldi, G., Kupelnik, B., & Munizza, C. (2004). Combined pharmacotherapy and psychological treatment for depression. *Archives of General Psychiatry*, 61, 714-719.
- Papworth, M. (2006). Issues and outcomes associated with adult mental health self-help materials: A "second order" review or "qualitative meta-review". *Journal of Mental Health*, 15(4), 387-409.
- Patton, M. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park: Sage.
- Paus, T., & Barrett, J. (2004). Transcranial magnetic stimulation (TMS) of the human frontal cortex: Implications for repetitive TMS treatment of depression. *Review of Psychiatric Neuroscience*, 29(4), 268-279.
- Perkins Gilman, C. A. (1996). *The yellow wallpaper*. London: Virago Press.
- Peterson, C., Maier, S., & Seligman, M. E. P. (1993). *Learned helplessness: A theory for the age of personal control*. New York: Oxford University Press.
- Peterson, C., & Seligman, M. E. P. (1985). The learned helplessness model of depression: Current status of theory and research. In E. E. Beckham & W. R. Leber (Eds.), *Handbook of depression: Treatment, assessment, and research* (pp. 914-939).
- Pico-Alfonso, M. A., Garcia-Linares, M. I., Celda-Navarro, N., Blasco-Ros, C., Echeburua, E., & Martinez, M. (2006). The impact of physical, psychological, and sexual intimate male partner violence on women's mental health: Depressive symptoms, posttraumatic stress disorder, state anxiety and suicide. *Journal of Women's Health*, 15(5), 599-611.
- Pierce, L. I., Wilkinson, L. K., & Anderson, J. (2003). Analysis of the concept of aloneness as applied to older women being treated for depression. *Journal of Gerontological Nursing*, 29(7), 20-25.
- Pilgrim, D., & Bentall, R. (1999). The medicalisation of misery: A critical realist analysis of the concept of depression. *Journal of Mental Health*, 8, 261-274.
- Pilgrim, D., & Rogers, A. (1997). Mental health, critical realism and lay knowledge. In J. M. Ussher (Ed.), *Body talk: The material and discursive regulation of sexuality, madness and reproduction* (pp. 33-49). London: Routledge.
- Plunkett, M. (2001). Serendipity and agency in narratives of transition: Young adult women and their careers. In D. P. McAdams, R. Josselson & A. Lieblich (Eds.), *Turns in the road: Narrative studies of lives in transition* (pp. 151-176). Washington, DC: American Psychological Association.
- Polkinghorne, D. (1988). *Narrative knowing and the human sciences*. Albany, NY: State University of New York Press.
- Pomeroy, E. C., Holleran, L. K., & Kiam, R. (2004). Postmodern feminism: A theoretical framework for a field unit with women in jail. *Social Work Education*, 23(1), 39-49.
- Pondé, M., & Santana, V. (2000). Participation in leisure activities: Is it a protective factor for women's mental health? *Journal of Leisure Research*, 12(4), 457-472.

- Rappaport, J. (2000). Community narratives: Tales of terror and joy. *American Journal of Community Psychology*, 28(1), 1-24.
- Read, J. (2005). The bio-bio-bio model of madness. *The Psychologist*, 18(10), 596-597.
- Read, J., Mosher, L., & Bentall, R. (2004). *Models of madness; Psychological, social and biological approaches to schizophrenia*. Hove: Brunner-Routledge.
- Renee. (1995). *Does this make sense to you?* London: Penguin.
- Rice, F., Harold, G., & Thapar, A. (2005). The link between depression in mothers and offspring: An extended twin analysis. *Behaviour Genetics*, 35(5), 565-577.
- Rice, P. L., & Ezzy, D. (1999). *Qualitative research methods: A health focus*. Melbourne, Australia: Oxford University Press.
- Richardson, R., & Richards, D. A. (2006). Self-Help: Towards the next generation. *Behavioural and Cognitive Psychotherapy*, 34, 13 - 23.
- Riedel-Heller, S. G., Matschinger, H., & Angermeyer, M. C. (2005). Mental disorders - who and what might help? Help-seeking and treatment preferences of the lay public. *Social Psychiatry Psychiatric Epidemiology*, 40, 167-174.
- Riessman, C. K. (1993). *Narrative analysis*. Newbury Park: Sage.
- Robinson, G. (2001). Psychotic and mood disorders associated with the perimenopausal period. *CNS Drugs*, 15(3), 175-184.
- Rogers, A., May, C., & Oliver, D. (2001). Experiencing depression, experiencing the depressed: The separate worlds of patients and doctors. *Journal of Mental Health*, 10(3), 317-333.
- Rogers, C. R. (1951). *Client-centred therapy*. Boston: Houghton Mifflin.
- Rogers, C. R. (1961). *On becoming a person: A therapist's view of psychotherapy*. Boston: Houghton Mifflin.
- Romans, S. E., Walton, V. A., McNoe, B., Herbison, G. P., & Mullen, P. E. (1993). Otago women's health survey 30-month follow-up I: Onset patterns of non-psychotic psychiatric disorder. *British Journal of Psychiatry*, 163, 733-738.
- Roness, A., Mykletun, A., & Dahl, A. A. (2005). Help-seeking behaviour in patients with anxiety order and depression. *Acta Psychiatrica Scandanavica*, 111, 51-58.
- Rose, N. (1989). *Governing the soul*. London: Routledge.
- Rose, N. (1996). *Inventing ourselves: Psychology, power, and personhood*. Cambridge: Cambridge University Press.
- Rosen, H. (1996). Meaning-making narratives: Foundations for constructivist and social constructionist psychotherapies. In H. Rosen & K. T. Kuehlwein (Eds.), *Constructing realities: Meaning-making perspectives for psychotherapists* (pp. 3-51). San Francisco: Jossey-Bass.
- Rossiter, A. (1998). Toward an alternative account of feminist practice ethics in mental health. *Affilia*, 13(1), 9-30.
- Roth, A., & Parry, G. (1997). The implications of psychotherapy research for clinical practice and service development: Lessons and limitations. *Journal of Mental Health*, 6, 367-380.
- Royal Commission on Social Policy. (1988). *The April report, II*. Wellington: Royal Commission on Social Policy.
- Rupke, S. J., Blecke, D., & Renfrow, M. (2006). Cognitive therapy for depression. *American Family Physician*, 73, 83-86.
- Sacco, W. P., & Beck, A. T. (1985). Cognitive therapy of depression. In E. E. Beckham & W. R. Leber (Eds.), *Handbook of depression: Treatment, assessment and research* (pp. 3-38). Homewood, Illinois: The Dorsey Press.



- Salkovskis, P., Rimes, K., Stephenson, D., Sacks, G., & Scott, J. (2006). A randomized controlled trial of the use of self-help materials in addition to standard general practice treatment of depression compared to standard treatment alone. *Psychological Medicine*, 36(3), 325-333.
- Sampson, E. E. (1998). Life as an embodied art: The second stage - beyond constructionism. In B. M. Bayer & J. Shotter (Eds.), *Reconstructing the psychological subject: Bodies, practices and technologies* (pp. 21 - 32). London: Sage.
- Sarbin, T. (Ed.). (1986). *Narrative psychology: The storied nature of human conduct*. New York: Praeger.
- Sareen, J., Cox, B. J., Afifi, T. O., Yu, B. N., & Stein, M. B. (2005). Mental Health Service use in a nationally representative Canadian survey. *Canadian Journal of Psychiatry*, 50(12), 753-761.
- Scattolon, Y. (2003). "I just went on .... There was no feeling better, there was no feeling worse": Rural women's experiences of living with and managing "depression". In J. M. Stoppard & L. M. McMullen (Eds.), *Situating sadness: Women and depression in social context* (pp. 162-182). New York: New York University Press.
- Scattolon, Y., & Stoppard, J. M. (1999). "Getting on with life": Women's experiences and ways of coping with depression. *Canadian Psychology*, 40(2), 205-219.
- Schreiber, R. (1996a). (Re)Defining my self: Women's process of recovery from depression. *Qualitative Health Research*, 6(4), 469-491.
- Schreiber, R. (1996b). Understanding and helping depressed women. *Archives of Psychiatric Nursing*, 10(3), 165-175.
- Schreiber, R. (1998). Clueing in: A guide to solving the puzzle of self for women recovering from depression. *Health Care for Women International*, 19, 269-288.
- Schreiber, R. (2001). Wandering in the dark: Women's experiences with depression. *Health Care for Women International*, 22, 85-98.
- Seligman, M. E. P. (1995). The effectiveness of psychotherapy: The consumer reports study. *American Psychologist*, 50(12), 965-974.
- Showalter, E. (1990). *The female malady: Women, madness, and English culture, 1830-1980*. New York: Penguin.
- Skaersaeter, I., Dencker, K., & Bergbom, I. (2003). Women's conceptions of coping with major depression in daily life: A qualitative, salutogenic approach. *Issues in Mental Health Nursing*, 24, 419-439.
- Skärsäter, I., Langius, A., Agren, H., Häggstrom, L., & Dencker, K. (2005). Sense of coherence and social support in relation to recovery in first-episode patients with major depression: A one-year prospective study. *International Journal of Mental Health Nursing*, 14, 258-264.
- Smith, L. T. (1999). *Decolonizing methodologies: Research and indigenous peoples*. Dunedin: University of Otago Press.
- Spence, S., Burns, J., Boucher, S., Glover, S., Graetz, B., Kay, D., et al. (2005). The *beyondblue* schools research initiative: Conceptual framework and intervention. *Australasian Psychiatry*, 13(2), 159-164.
- Spencer, D. C., & Nashelsky, M. L. S. (2005). Counselling or antidepressants for treating depression? *American Family Physician*, 72(11), 2309-2310.
- Spinelli, M. G., & Endicott, J. (2003). Controlled clinical trial of interpersonal psychotherapy versus parenting education program for depressed pregnant women. *The American Journal of Psychiatry*, 160(3), 555-562.

- Stafford, R. S., MacDonald, E. A., & Finkelstein, S. N. (2001). National patterns of medication treatment for depression, 1987 to 2001: Primary care companion. *Journal of Clinical Psychiatry*, 3, 232-235.
- Steen, M. (1995). Essential structure and meaning of recovery from clinical depression for middle-adult women: A phenomenological study. *Issues in Mental Health Nursing*, 17, 73-92.
- Steen, M. (1996). Essential structure and meaning of recovery from clinical depression for middle-adult women: A phenomenological study. *Issues in Mental Health Nursing*, 17, 73-92.
- Stevinson, C., & Ernst, E. (1999). Safety of hypericum in patients with depression. *CNS Drugs*, 11(2), 125-132.
- Stoppard, J. M. (1997). Women's bodies, women's lives and depression: Towards a reconciliation of material and discursive accounts. In J. M. Ussher (Ed.), *Body talk: The material and discursive regulation of sexuality, madness and reproduction* (pp. 10-32). London: Routledge.
- Stoppard, J. M. (1998). Dis-ordering depression in women: Toward a materialist-discursive account. *Theory and Psychology*, 8(1), 79-99.
- Stoppard, J. M. (1999). Why new perspectives are needed for understanding depression in women. *Canadian Psychology*, 40(2), 79-90.
- Stoppard, J. M. (2000). *Understanding depression: Feminist social constructionist approaches*. London: Routledge.
- Stoppard, J. M., & Gammell, D. J. (2003). Depressed women's treatment experiences: Exploring themes of medicalization and empowerment. In J. M. Stoppard & L. M. McMullen (Eds.), *Situating sadness: Women and depression in social context* (pp. 39-61). New York: New York University Press.
- Stoppard, J. M., & McMullen, L. M. (Eds.). (2003). *Situating sadness: Women and depression in social context*. New York: New York University Press.
- Studd, J., & Panay, N. (2004). Hormones and depression in women. *Climacteric*, 7, 338-346.
- Sullivan, P., Neale, M., & Kendler, K. (2000). Genetic epidemiology of major depression: Review and meta-analysis. *American Journal of Psychiatry*, 157, 1552-1562.
- The London Feminist Salon Collective. (2004). The problematization of agency in postmodern theory: As feminist educational researchers, where do we go from here? *Gender and Education*, 16(1), 25-33.
- Thompson, J. M. (1995). Silencing the self: Depressive symptomatology and close relationships. *Psychology of Women Quarterly*, 19, 337-353.
- Tuval-Mashiach, R. (2006). "Where is the story going?" Narrative forms and identity construction in the life stories of Israeli men and women. In D. P. McAdams, R. Josselson & A. Lieblich (Eds.), *Identity and story: Creating self in narrative* (pp. 249 - 268). Washington, DC: American Psychological Association.
- Ussher, J. M. (1991). *Women's madness: Misogyny or mental illness?* London: Harvester Wheatsheaf.
- Ussher, J. M. (1992). The demise of dissent and the rise of cognition in menstrual-cycle research. In J. T. E. Richardson (Ed.), *Cognition and the menstrual cycle* (pp. 132-173). New York: Springer-Verlag.
- Ussher, J. M. (2000a). Women's madness: A material-discursive-intrapsychic approach. In D. Fee (Ed.), *Pathology and the postmodern: Mental illness as discourse and experience* (pp. 207-230). London: Sage.

- Ussher, J. M. (2003a). Biology as destiny: The legacy of Victorian gynaecology in the 21st century. *Feminism and Psychology*, 13(1), 17-22.
- Ussher, J. M. (2003b). The ongoing silencing of women in families: An analysis and rethinking of premenstrual syndrome and therapy. *Journal of Family Therapy*, 25(4), 388-405.
- Ussher, J. M. (2004). Biological politics revisited: Reclaiming the body and the intra-psychic within discursive feminist psychology. *Feminism and Psychology*, 14(3), 425-430.
- Ussher, J. M. (Ed.). (1997). *Body talk: The material and discursive regulation of sexuality, madness and reproduction*. London: Routledge.
- Ussher, J. M. (Ed.). (2000b). *Women's health: Contemporary international perspectives*. Leicester: British Psychological Society.
- Van de Vliet, P., Knapen, J., Fox, K. R., Onghena, P., David, A., Probst, M., et al. (2003). Changes in psychological well-being in female patients with clinically diagnosed depression: An exploratory approach in a therapeutic setting. *Psychology, Health and Medicine*, 8(4), 399 - 408.
- Vidler, H. C. (2005). Women making decisions about self-care and recovering from depression. *Women's Studies International Forum*, 28, 289-303.
- Walsh, A. E. S. (1998). Women and mood: Biological considerations. In S. E. Romans (Ed.), *Folding back the shadows; A perspective on women's mental health* (pp. 165-176). Dunedin: University of Otago Press.
- Walters, V. (1991). Beyond medical and academic agendas: Lay perspectives and priorities. *Atlantis: A Women's Studies Journal*, 7(1), 28-35.
- Walters, V. (1993). Stress, anxiety and depression: Women's accounts of their health problems. *Social Science and Medicine*, 36, 393-402.
- Walters, V., Avotri, J. Y., & Charles, N. (2003). "Your heart is never free": Women in Wales and Ghana talking about distress. In J. M. Stoppard & L. M. McMullen (Eds.), *Situating sadness: Women and depression in social context*. New York: New York University Press.
- Wang, J., Patten, S. B., Williams, J. V. A., Currie, S., Beck, C. A., Maxwell, C. J., et al. (2005). Help-seeking behaviours of individuals with mood disorders. *Canadian Journal of Psychiatry*, 50(10), 652-659.
- Ward, E., King, M., Lloyd, M., Bower, P., Sibbald, B., Farrelly, S., et al. (2000). Randomised controlled trial of non-directive counselling, cognitive-behaviour therapy, and usual general practitioner care for patients with depression, I: Clinical effectiveness. *BMJ*, 321, 1383-1388.
- Waring, M. (1988). *Counting for nothing*. Auckland, New Zealand: Allen and Unwin.
- Weedon, C. (1987). *Feminist practice and poststructuralist theory*. Oxford: Blackwell.
- Wengraf, T. (2001). *Qualitative research interviewing: Biographic narrative and semi-structured methods*. London: Sage.
- White, M. (1993). Deconstruction and therapy. In S. Gilligan & R. Price (Eds.), *Therapeutic conversations* (pp. 22-61). New York: W.W.Norton and Company.
- White, M. (1995). *Re-authoring lives: Interviews and essays*. Adelaide, South Australia: Dulwich Centre Publications.
- Whitty, P., & Gilbody, S. (2005). NICE, but will they help people with depression? The new National Institute for Clinical Excellence depression guidelines. *British Journal of Psychiatry*, 186, 177-178.
- Wilson, J. D. (1997). *Doctor I'm in trouble: What happens when women experience depression and ask their GP for help?* Unpublished Master of Arts in Psychology, University of Auckland, Auckland.

- Wilson, J. D., & Read, J. (2001). What prevents GPs from using outside resources for women experiencing depression? A New Zealand study. *Family Practice*, 18(1), 84 - 86.
- Winslade, J., & Monk, G. (1999). *Narrative counseling in schools: Powerful and brief*. Thousand Oaks, California: Corwin Press.
- Wirth-Cauchon, J. (2000). A dangerous symbolic mobility: Narratives of borderline personality disorder. In D. Fee (Ed.), *Pathology and the postmodern: Mental illness as discourse and experience* (pp. 141-162). London: Sage.
- Wood, D. A., & Burgess, P. M. (2003). Epidemiological analysis of electroconvulsive therapy in Victoria, Australia. *Australian and New Zealand Journal of Psychiatry*, 37, 307 - 311.
- Woolford, P. (1990). A cultural response to depression. *New Zealand Family Physician*(Winter), 129-130.
- Yapko, M. (1997). *Breaking the patterns of depression*. New York: Doubleday.
- Yardley, L., & Murray, M. (2004). Qualitative analysis of talk and text: Discourse and narrative analysis. In D. F. Marks & L. Yardley (Eds.), *Research methods for clinical and health psychology* (pp. 90-101). London: Sage.

# Glossary of Māori Terms

<b>Hapū</b>	<b>Sub-tribe</b>
<b>Hui</b>	<b>Gathering, meeting</b>
<b>Iwi</b>	<b>Tribal grouping</b>
<b>Kohanga Reo</b>	<b>Language nest ( Māori pre-school)</b>
<b>Marae</b>	<b>Meeting area of whanau or iwi</b>
<b>Pākehā</b>	<b>non – Māori, European, Caucasian</b>
<b>Paiheretia</b>	<b>Model of holistic well-being</b>
<b>Taonga</b>	<b>Treasure</b>
<b>Taha Tinana</b>	<b>Physical wellbeing (being safe)</b>
<b>Taha Hinengaro</b>	<b>Mental wellbeing (being calm)</b>
<b>Taha Whanau</b>	<b>Social wellbeing (being connected)</b>
<b>Taha Wairua</b>	<b>Spiritual wellbeing (being content)</b>
<b>Te Reo</b>	<b>Maori language</b>
<b>Te Whare Tapa Wha</b>	<b>The four cornerstones of the house</b>
<b>Tikanga Maori</b>	<b>Maori customs</b>
<b>Tohunga</b>	<b>Healer</b>
<b>Tupuna</b>	<b>Ancestor</b>
<b>Whanau</b>	<b>Extended family</b>
<b>Wairua</b>	<b>Spirit, soul</b>

# APPENDICES

## ***APPENDIX A***

**A (i) Poster Version One**

**A (ii) Poster Version Two**



# Women and Depression

**I am undertaking research into the many and varied ways that women have found to cope with depression.**

I want to talk with women who

- In the past, have had their life seriously disrupted by their experience of depression  
*and*
- Now have a life that is not seriously disrupted by depression  
*and*
- Have discovered things to help them to cope with or overcome depression. Whilst they may have used counselling, therapy or medication, I particularly want to hear about 'non-professional' things that have helped in the re-building of their lives.

If this sounds like you, and you are willing to consider being interviewed for this project, please contact me for further information. I am carrying out this project as part of my PhD at the University of Waikato.

**My name is Jan Wilson, and I can be contacted in any of the following ways:**

**Telephone: 410 9508**

**e-mail:** [jandwilson@hotmail.com](mailto:jandwilson@hotmail.com)

**Post:** Jan Wilson  
Health and Counselling  
Akoranga Campus  
AUT  
Private Bag 92006  
AUCKLAND

[illegible]



# Have You Overcome Depression?

## Your Experience Could Help Other Women

**I am undertaking research into the many and varied ways  
that women have found to cope with depression.**

I want to talk with women who

- In the past, have had their life seriously disrupted by their experience of depression  
*and*
- Now have a life that is not seriously disrupted by depression  
*and*
- Have discovered things to help them to cope with or overcome depression. Whilst they may have used counselling, therapy or medication, I particularly want to hear about 'non-professional' things that have helped in the re-building of their lives.

If this sounds like you, and you are willing to consider being interviewed for this project, please contact me for further information. I am carrying out this project as part of my PhD at the University of Waikato.

**I am Jan Wilson, I can be contacted in any of these ways:**

**Telephone:** 410 9508

**e-mail:** [jandwilson@hotmail.com](mailto:jandwilson@hotmail.com)

**Post:** Jan Wilson  
Health and Counselling  
AUT  
Private Bag 92006  
AUCKLAND

## ***APPENDIX B***

### **NZAC Advertisement**



## **WOMEN AND DEPRESSION**

**Notice seeking Counsellor Participants – to be published in  
the Auckland and Waikato NZAC newsletters.**

### **WOMEN AND DEPRESSION Research Project**

I am a counsellor working at AUT, and have been part of NZAC for 20 years. I am currently doing my PhD at the University of Waikato, researching women's experiences of depression .

I will interview women whose lives have been seriously disrupted by their experience of depression, but who have found ways to cope and to restore their lives. I am particularly interested in 'non-professional' responses and ideas that women have found useful.

Many of my participants will come from the Auckland community where I live. However, I am also wanting to work collaboratively with counsellors who have themselves experienced depression, and found a way to re-build their lives. As well as interviewing them I plan to bring some of these counselling women together in a group. I hope we can explore some of these experiences, and the ways that living with depression and then reducing its effects, has impacted on their professional work as well as their personal life.

If you meet these 'criteria' and would like to consider taking part in this research, please contact me, and I will send you further information. I would be very happy to discuss any issues related to the research with you.

Jan Wilson  
09 410 9508  
jandwilson@hotmail.com

## ***APPENDIX C***

**Leaflet for advertising in Gym**

**My name is Jan Wilson, and I  
can be contacted in any of the  
following ways:**

**Telephone:**

**410 9508**

**e-mail:**

**[jandwilson@hotmail.com](mailto:jandwilson@hotmail.com)**

**Post:**

**Jan Wilson  
Health and Counselling  
Akoranga Campus  
AUT  
Private Bag 92006  
AUCKLAND**

## **WOMEN AND DEPRESSION**

**Can physical activity  
help women to cope  
with depression?**



**My name is Jan Wilson and I am undertaking research into the many and varied ways that women have found to cope with depression.**

**I am carrying out this project as part of my PhD at the University of Waikato**

**I have been a member of the North Shore YMCA Fitness Centre for five years. I work at AUT as a Student Counsellor on the Akoranga Campus, but am on leave this year to do this research project.**

**Through this YMCA advertising I hope to contact women who have been seriously depressed, but whose lives have been improved partly through their involvement in physical activity.**

#### **I want to talk with women who**

- In the past, have had their life seriously disrupted by their experience of depression.*
- and*
- Now have a life that is not seriously disrupted by depression.*
- and*
- Have discovered things to help them to cope with or overcome depression. Whilst they may have used counselling, therapy or medication, I particularly want to hear about 'non-professional' things that have helped in the re-building of their lives.*

**If this sounds like you, and you are willing to consider being interviewed for this project, please contact me for further information.**

**Contact details are given on the back of this leaflet.**

## ***APPENDIX D***

### **Pre-selection Interview – Brief Outline**



## **WOMEN AND DEPRESSION**

### **Pre-Selection Interview – Brief Outline**

The interview will be carried out in person, or on the telephone, by Jan Wilson.

The potential participant will have already responded to an advertisement and asked for and received the Information Sheet. They will have decided that they may wish to participate and that they meet the criteria. The purpose of this brief interview is to answer any questions the potential participant may have about the project and the interview process, and for the interviewer to determine whether they are a suitable participant.

#### **Points to be Discussed:**

- Does the participant have any questions, or issues they want to discuss.
- I want to talk with women whose lives have, in the past, been seriously disrupted by the experience of depression. Does this sound like you ? Can you tell me a little bit about that time?
- I am interested in how your life is now – now that your life is restored to a state where depression is no longer causing serious disruption. Can you tell me a little bit about your life now?
- I am wanting to hear the experiences of women whose lives have moved through depression to something more manageable. But I want to hear as many different stories as I can, and I am especially interested in things that have helped than are not only medication or counselling/ therapy. Have you found some other things helpful in your life beyond the major disruption of depression?

If I feel that this person is not going to be a suitable participant, then I will explain that to them, and give them reasons for my decision. One reason may be that, unfortunately, I have already selected someone who has used similar ways to overcome depression. Another reason may be that they have misunderstood the criteria, and are still living a life that is seriously disrupted by depression. In the latter case I would attempt to ensure that they do have some support available. Anyone who expresses an interest will be offered the chance to receive the summary of information at the conclusion of the study.

If I feel that this person is a suitable participant, then I will explain more about the interview, and check that they understand the length, content and potentially distressing nature of the interview. I will also check out appropriate times and place for the interview, and make sure they will feel comfortable with me as the interviewer.



## ***APPENDIX E***

### **Participant Information Sheet**

Faculty of Arts & Social Sciences  
Te Kura Kete Aronui  
The University of Waikato  
Private Bag 3105  
Hamilton, New Zealand



The  
University  
of Waikato  
Te Whare Wānanga  
o Waikato

Department of Sociology and Social  
Policy

### Women's & Gender Studies

#### Programme

Telephone 64-7-838 4718

Facsimile 64-7-838 4258

Email [caro@waikato.ac.nz](mailto:caro@waikato.ac.nz)

<http://www.waikato.ac.nz/sass/>

## WOMEN AND DEPRESSION INFORMATION FOR PARTICIPANTS

### ABOUT THE RESEARCHER

My name is Jan Wilson, and I am a 55 year old Pakeha woman. I am undertaking this project for my PhD from the University of Waikato where I am a student in the Women's and Gender Studies Programme, within the Department of Sociology and Social Policy. I hope that I will benefit from the project by achieving my degree. However, I also hope that the knowledge, experience and wisdom which participating women contribute will be of benefit to themselves and to other women who experience depression.

I have not experienced depression to an extent that it has seriously disrupted my life. However, in my work as a counsellor during the last 25 years, I have met many women whose lives have been disrupted in a serious way by their experience of depression. I have been impressed by *the variety of ways they have discovered to help themselves* to restore their lives. Whilst their stories may have included medication and/or counselling and therapy, many of them have found other things that have been very important in the re-building of their lives. I have chosen to attend to the stories of women like them and to honour the 'lay' wisdom that many women find to help them combat depression.

### ABOUT THE PROJECT

I am interested in gathering from women their stories of living through the experience of depression.

I want to talk with women who

- In the past, have had their life seriously disrupted by their experience of depression  
*and*
- Now have a life that is not seriously disrupted by depression.  
*and*
- Have discovered things to help them to cope with or overcome depression. Whilst they may have used counselling, therapy or medication, I particularly want to hear about 'non-professional' things that have helped in the re-building of their lives.



I plan to listen to the stories of about twenty women, and am seeking as wide a variety as possible of different useful responses to depression. I will have a short conversation with any woman who is interested in participating, and decide, with her, on the basis of that discussion whether to carry out a longer, audio-taped interview. Whilst I appreciate the wisdom of any woman who meets the criteria, I may not be able to accept all of them into the project because I am looking for a range of different stories.

Those women who are selected to take part, and who choose to participate will tell their stories to me, and these stories will be audio taped. All stories will be transcribed and I will then examine them in a number of ways, looking for the variety of ways that women have found to cope with depression, and also at the range of their experiences of depression and its effect on their lives. As well as looking at individual stories, I will be looking for ideas, inspirations and understandings that enter into more than one story. The context within which the experience of depression occurred will be considered, along with social understandings of women's depression and 'normal' life experience.

### **Participation**

Your participation is voluntary. I would like you to consider the information in this document, and if you feel you would like to talk with me about the project, and the part you might take in it you can contact me through letter, telephone or e-mail (all listed at the end of this information document). Once you have agreed to take part, and been accepted as a participant you still have the right to completely withdraw from the research at any stage. This right includes an opportunity to change, or have erased any part or the whole of my interview with you.

I am inviting you to be involved in an interview which should take no more than two hours, and may take less. I will ask questions to guide you through your story of your life with depression. You do not have to answer the questions, and can stop the interview at any time. You will also have the opportunity to talk about parts of your story which are important but which I have not asked about. I would like to have the opportunity to contact you after the interview for a follow up – this will give me the chance to check anything that I do not understand, and you the chance to tell me what the interview was like for you, and to add anything you thought of afterwards.

I plan to do all the interviews myself, however, if you feel that I may not be a safe or appropriate person to carry out the interview, but you would still like to take part, please contact me, and we will consider some alternatives. This might result in my finding a different interviewer, or you may choose to have a support person or group with you at the interview.

### **Confidentiality**

After the interview the tape-recording will be written out in full (transcribed), but any information that may identify you will be removed. You will have had the opportunity at the time of the interview to choose a name that you would like used for your story. You will be offered a copy of the audio tape and of the transcript, and can decide whether you would like any sections to be removed. No material which could personally identify you will be used in any reports on this project.





Your contact name, address and telephone number, interview tapes and all material relating to the interviews, will be stored in a locked secure place. All material will be held for five years after any publication of the research and then tapes will be erased and transcripts with any identifying material destroyed.

The intent of this project is not therapeutic or counselling in nature. At the time of the interview I will check with you about support that is available to you in case taking part in the project is distressing for you.

### **Results**

The results will initially be incorporated in my PhD and published as a thesis for the University of Waikato. I hope that the work will also result in publication of scholarly articles and possibly a book. Information from the project may also be presented at workshops and conferences, and I will discuss with you whether you wish to be kept informed about this sharing of information.

### **Ethical Commitments**

I am bound by and committed to the Ethical Guidelines of the New Zealand Association of Counsellors.

### **Concerns and Complaints**

Any questions or complaints you may have about the project can be addressed to me, or to one of my supervisors ( Dr Hilary Lapsley and Professor Jane Ritchie) who can be contacted at addresses which will be listed on the Consent Form you will sign and have a copy of it you choose to participate.

The project has been given ethical approval by the University of Waikato Ethics Committee. Should the need arise for a formal complaint to be made about the project, contact the University of Waikato.

IF YOU ARE INTERESTED IN TALKING WITH ME ABOUT THE PROJECT, AND THINK YOU MAY CHOOSE TO PARTICIPATE, PLEASE CONTACT ME AT ONE OF THE FOLLOWING: Let me know where I can ring you, e.mail you or write to you.

By Post: Jan Wilson  
Womens and Gender Studies  
Department of Sociology and Social Policy  
University of Waikato  
Private Bag 3105  
HAMILTON

By e mail: jandwilson@hotmail.com

By Phone: 09 410 9508

## ***APPENDIX F***

### **Introductions to the Women**

## Introductions to the Women

In this Appendix I introduce the women whose narratives are analysed in this thesis. Wherever possible I will include their own words. I have, however, had to alter some identifiable information to maintain the women's anonymity.

Most of the women I met only briefly, during 2000, when they shared their narratives. The introductions I make here are based on these brief meetings, and can not be expected to represent the full richness of their lives. If I were to hear their stories again now, they would be different in many ways. In making these introductions I am acknowledging the embodied nature of these women's narrated lives. The process of analysis can fragment these lives, diminishing their complexity, and seeming to remove much of the reality of distress and its impact. These introductions are an attempt to counter such fragmentation. These brief introductory stories provide a context of whole lives within which to read The Middle section of the thesis; the five analytic chapters which are full of fragments of stories.

After I had written these introductions I attempted to contact all the women again and invite them to read their own introduction and decide if they approved. Fourteen women got back in touch with me, and all were happy with the way I had represented them.

It has been difficult to decide how best to organise these introductions. I considered presenting the women one by one in the alphabetical order of their chosen names, or chronologically from the oldest to the youngest. In the end I decided to introduce them in a way that highlights one aspect of their narratives; the number of years of the woman's life that she talks of as disrupted by depression. For every woman the disruption was serious. However, whilst some women tell of a life disrupted from birth or before through until well into adulthood, others talk of a life which was suddenly disrupted, and for a relatively brief time.

### ***Depression came out of the blue***

Nine of the women talked of depression coming into their lives "out of the blue". Three of these women, Hannah, Charlotte and Katy, experienced the first episode of depression around a time in their early adult life when they had immigrated to New Zealand and had given birth. Christine and Kay also had their lives first interrupted by depression around the time of childbirth. Three other women, Jane, Isobel and Fiona talk of depression disrupting their lives seriously at the time when their marriage broke down. Linda's story is also one of relatively sudden disruption and equally sudden resumption of a meaningful life. I will now introduce these first nine women.

### **Hannah**

Hannah is the oldest of the participants. She was seventy when she told her story, and she clearly distinguished two times when her life was seriously disrupted by depression; one in her twenties, and the other quite recently. She grew up in Britain as part of a family where women were strong. She said:

*We were very much a matriarchal family. Very strong women. Always strong women. Very dominant women, really, when I look back. And that's what my present husband used to say to me, he said "Don't ever try and tell me that you're a shrinking violet."*

*Because I used to say to him I was a shrinking violet. Oh he said, goodness he said, "You know, he said, "None of you are, all you women are strong in that family."*

Hannah came to New Zealand in her late teens, married and had children. It was at this time that she first became depressed. She was isolated as an immigrant and young mother, and took some years to reclaim her life. For the following forty years she lived a fulfilling and successful life running a business, being an active mother and enjoying many creative activities. She has had a strong and growing commitment to developing her own spirituality. In her sixties she again had her life disrupted by depression, and she connected this with the collapse of a business that she and her husband had built up with extremely hard work over a number of years.

Hannah is a determined woman, and has no patience for injustice. She said of herself *"I put my back to the wall and I'll fight, I'll bring out the boxing gloves, come hell or high water."* This spirit is brought into action when Hannah sees injustice, or unfair judgements of people. She has come to realise how important it is to be tolerant, and how hard it is to know what life is like for anyone else:

*People can be so judgmental. They don't stand in your moccasins but boy they can really let you have it both barrels. About what they think you should do. And I've learned that that is something that you never do with people. Unless you stand in their moccasins, and how do you know? How do you know?*

## **Charlotte**

Charlotte also came to New Zealand from Britain as a young adult. When she told her story she was in her fifties, and her life had been severely disrupted by depression thirty years earlier, when she was a young mother. Like Hannah she was isolated in a new country with few support people and not a lot of money. Much of her story refers to family, both her large and supportive family of origin, and the family centred on her husband and their children. Also like Hannah, she is a woman of strong character. She is intelligent and creative and works in a high level, responsible professional career. She understands people and systems, and has a good gender and structural analysis. When she talked of a situation where she needed to challenge institutional structures on behalf of a family member she explained her successful negotiations by saying: *"its working the system really. I'm just bolshy and I will .... I know how the system works."*

As well as being bolshy, Charlotte talks of herself as very much a people person, she said *"I get on well with most people, I like people, I like talking"*. She also has a longstanding and strong sense of community. She recalled her early life and said:

*I knew very clearly who my third cousin was , and who my fourth cousin was, and who my fifth --- and the second, and how they got to be there, and who married who, and --- and I can always remember people having these long conversations about "Well, you know old Fred, well he married the girl so and so from such and such , now her father was married twice and they were married too, and they would go on and on and on like this, so , I mean , my earliest memories are of people doing that sort of thing...."*

## Katy

Katy had experiences similar, in many ways, to those of Charlotte and Hannah. She grew up in the northern hemisphere, in a number of different countries, and went to a boarding school in Britain from the age of nine years. She was in her late fifties when she was interviewed, and included two discreet experiences of depression in her narrative. The first occurred when her second child was born. This was not long after her immigration to New Zealand, and at a time when she was isolated from family and friends because of immigration, poverty, the remoteness of the suburb where she lived, and the complete lack of transport. She talked of depression again disrupting her life many years later. On this occasion it was after a particularly stressful time related to the marriage of one of her daughters.

Katy is a very independent woman, with a strong commitment to preserving the environment, as well as an enjoyment of nature and of creative crafts. She has an enduring marriage, and has raised a relatively large family. Throughout her life Katy has enjoyed her own company in preference to taking part in “*meaningless social chatter*”. She has a strong Christian faith, and this has enabled her to accept the death of one her children in a traffic accident when he was in his late teens. From her story it is clear that, for her, neither this loss, nor her loneliness as a young girl in boarding school resulted in depression. Katy takes pride in describing herself as a “*feisty old crone*” and she tells a story of being with a group of women at a party where:

*three women spent the entire time wondering how they could get the money for a face-lift. I said I didn't want a face-lift. I said. “I damn well earned my lines”. I said “I'd like to think that you know, by the end of my life, my epitaph was going to be more than She looked beautiful for God's sake.” Better be beautiful on the inside than waste your time on the outside.*

## Christine

For Hannah, Charlotte and Katy the experience of child birth, coupled with isolation resulting in part from immigration, was associated with depression disrupting their lives. Christine also tells of depression coming into her life at the time of the birth of her first child, but she talks of this experience, not in relation to isolation and lack of support, but in terms of anxiety and a need to be a perfect mother. The depression “*came out of the blue*” along with her first pregnancy. She grew up in New Zealand, had a good job and is married to a man she talked of as supportive, loving and understanding. She describes her childhood as happy, loving and nurturing. When she looked back, however, she recognised that she had been positioned within a very strong discourse of woman as housewife. She said:

*I really now see the way it was .... the socialization of women, and how it works to control us .... and all the expectations, and what women have to be. .... And I used to .... wash floors before I left to do a day's work. I used to leave at quarter to eight, and I would be up washing floors. Now the house can be a pig sty and I, I'm over that. There was all sorts of things with being perfect.*

Christine, like Hannah and Katy, had two distinct experiences of her life being disrupted by depression. In her case the second time was more than ten years after the first. It again ‘came out of the blue’ and was clearly connected with her involvement in a fatal accident, which was not in any way her fault, but which was extremely traumatic. Her life again became seriously disrupted by anxiety and depression. By



the time she told her story Christine could see her own strengths, and she was very aware of the connections between her care of her body and her ability to prevent depression and anxiety from disrupting her life. She explained that she was:

*a person who needs the outdoors. I very much need to do stuff outside. I need to walk and think and look and --- and I need time out .... I don't necessarily need to do it alone, but, I find city life very stressful, and I need to walk and smell and look and touch, and I really need grounding with the earth and the bush and the sea. That is, possibly, one of my greatest things.*

## Kay

Kay, like Christine, told how her adult life had been seriously disrupted on two separate occasions by depression. The first was at the time of the birth of her oldest child, and the second ten years later when she was becoming increasingly aware of the need to end her marriage. She talked of the marriage as being characterised by poor communication, and complicated by the impact of a head injury her husband had sustained in a car accident. She explained that “*he had a head on smash on the open road that he contributed to significantly. And he was very, very badly injured.*”

She, like Christine, made some meaning of her life journey through a feminist analysis, focusing not on the domestic expectations, but on the denial of intellect. She had attended a traditional single sex school which she described as having taught her a “*load of old cobblers and crap*”. Before the birth of her children she had begun to resist her earlier learning about women’s capabilities, and advanced to a high performance job with a lot of autonomy and respect. This career was interrupted when she became a full-time mother.

Kay told me her story ten years after the second intrusion of depression into her life. She was by this time a university graduate and a confident and successful professional career woman, and single mother of two teenage daughters. She had drawn on her intelligence, her analytic abilities, her enthusiasm for learning, and her awareness that “*other women were the key for me*” to live a life no longer disrupted by depression. During the interview, which took place in her home, Kay showed me a book which for her symbolised some significant learning. The book was a photographic study of mother’s roles, and she had brought it out before I arrived, knowing it was an important representation of her journey. She had been introduced to this book by her daughter, who was a keen photographer. Kay found particular meaning in the picture ‘Mother as Road Kill’, which shows an older woman in a fur coat lying spreadeagled on the road. She said of the book that it is a “*statement of the restricted options in the fifties that women had*”. She goes on to comment:

*....its just the most --- the most amazing set of photography.... they are just so illuminating, deep, profound, funny. And the fact that a mother and daughter can collaborate on something like that, as a statement of reduced options for women, is just amazing. [My daughter] and I sit and look at it. She looks at it from a technical aspect. And I look at it for the symbolism and the meaning. I mean “Mother as Road Kill!!*

## Jane

In their narratives, Jane, Isobel and Fiona all connected their experiences of depression with the breakdown of their marriages. Where Kay had considered carefully, and analysed thoroughly her situation before herself making a decision to

leave her marriage, these three women all tell of their marriages ending abruptly and unexpectedly through decisions or actions of their husbands. For all of them, the position of wife, mother and family member had become central to their sense of themselves. The unexpected ending of their being 'wife' forced them into a re-consideration of the meaning of their lives.

Jane was very clear that the disruption of her life by depression was limited in time. She described it as a *"major episode which I've come through and I'm out of. I think I'm one of the 50% that don't relapse"*. Where Christine used the phrase *"came out of the blue"*, Jane said *"it was kind of un-announced, my husband of 18 years told me that he was leaving one weekend, without very much warning"*. Jane went on to reflect on this event, and realised that the warning signs had been there for a long time, and that the marriage had had a lot of conflict, but the sudden shock was the realisation that her husband no longer was committed to what she considered to be a shared belief that *"marriage was for keeps"*. On discovering this Jane went into *"shock for the weekend, and cried solidly for a whole Saturday"*. Depression then totally disrupted her life for some months.

Jane read about depression and about separation as part of her journey of recovery. She explained how she had always resourced herself through books.

*I always feel like you need to .... be one step ahead of difficult situations .... I did a lot of reading before my children became teenagers about adolescent problems, and you know, I did reading when I thought about marriage, before we got married. And we went to courses and things, and you know, I'll be reading about old age before I get there, and how to make the most of it.*

## Isobel

Isobel, like Jane discovered suddenly that her seventeen year old marriage was over. For Isobel this happened when she found out that her husband was involved with another woman. She was a qualified professional, but she had not worked whilst her three children were growing up. She includes in her narrative a number of references to a very violent upbringing, but structures the 'depression' story around the ending of her marriage.

Isobel's story of journeying beyond the disruption of depression focuses on the way that she re-built her life and her sense of being a worthwhile woman around her career, her parenting of her children, her creativity and her female friendships. Although it was difficult, she discovered that she did not need to depend upon a relationship with a man for security. At first her strongest fear was that in losing her marriage she would *"lose that security"*. Without her husband she remembered that she felt there was *"no meaning to my life"*.

After real desperation, including suicide attempts, hospitalisation and enormous anger, Isobel began to reconstruct her life. She made music, as she had done for most of her life. She worked on her creative crafts, she kept regular and close contact with her women friends, and she focused increasingly on supporting her three children emotionally and financially. She returned to work, and developed a successful career, and more importantly she learned to value herself. She reflected back on this change in herself and said:

*it was losing my security that, when I look back at it, that's what scared me. Not losing [my husband for himself] but losing that security and being on my own again and having to fight all the time. Now I enjoy it. Over the seventeen years .... I lost my own self-esteem.*

*I lost my decision-making power. When I look back on it I wouldn't go and buy anything for the house unless I checked with [my husband] first. I wouldn't make any decisions about the kids unless I checked with him first. I wouldn't make a decision about going out for an evening with my girlfriends unless it was okay with my husband and that he wasn't tied up with work. So when I was left .... all these decisions were thrown at me and I didn't know what to do with them. I didn't know how to cope with them. I didn't know how to make decisions and that scared me. It really was scary .... just knowing that .... all this responsibility was thrown at me and I didn't want it. I didn't want the responsibility and slowly I've come out of that and I make decisions now. If they're wrong well I don't answer to anybody. If I go and splash a whole lot of money at the Casino, which I did last weekend, that's my problem. I don't have to justify anything to anybody and that's good.*

## **Fiona**

Fiona is the third of the women who clearly structured her story of depression around the time when her marriage ended. She began her narrative with a reminiscence about her happy childhood and marriage. She recalled:

*I had met the most wonderful man, and we were right for each other, and we got engaged and we got married. And we waited. Well it was at that time we knew we wanted to get a house, and put a deposit on a house. And we also wanted to travel overseas before we had children. So we pooled together, and we thought -- well. And we were very happy, and I was happy. I was a happy child, I grew up in a good family*

In telling this happy beginning it was as though she was setting the scene for the complete shock of discovering, after more than twenty years of seemingly wonderful marriage, that her husband no longer loved her. At the time she was delighting in discovering that she was intellectually capable. She was finishing a high level professional degree, and remembered, *"I was so busy and I was so proud of myself, and I was feeling my power for the first time."* She was not aware that her *"marriage was grinding to a halt."*

Fiona was hardly recovering from the months of depression associated with the ending of her dream marriage when she needed to undergo major surgery, after which she returned to work prematurely. The stress of this second trauma resulted in a renewed experience of depression. Fiona has struggled to overcome these intensely distressing disruptions to her life. At the time she told her story they were still recent experiences, her marriage had ended four years earlier, and she was still recuperating from the post-operative depression. Nevertheless she had an inspiring story to tell of how she re-created a meaningful life.

Central to Fiona's story was her decision, with the help of a long standing friend, to follow up her childhood dream of taking up an adventurous sport, usually associated with men. Through this activity she became part of an amazing group of women. She was bubbling with enthusiasm when she described this new part of her life.

*I had never met such a characterful bunch of women in my life. And I belong to four different women's organizations, and each of them have their own sorts of women in them, with their own flavour. And I've*

*loved my women's organizations and I wouldn't be without them, and I still support them, but this one just blew me away. Because, it is old women, young women, fat women, thin women, rich women, poor women, clever women and stupid women. There are the smokers and the drinkers and there's the health addicts. And there's just every kind of women. There's lesbians who are very well adjusted. And there's lesbians who are not. And there's the tattooed ones, and the pierced ones, and there's the very ordinary middle-classy ones. And I just took my place. It was just fantastic. And I thought these girls, they laugh all the time, they tell very rude jokes.*

She says that after becoming involved in this sport she has “never looked back”.

## **Linda**

Linda's story makes a unique contribution to this project, and has a number of elements that are quite different from the other narratives. Depression did not appear in her life “*out of the blue*”, in fact it seemed to her, for more than ten years of her adult life, that depression had come as a consequence of childhood anxieties and losses. This belief was supported by a therapist whom she attended at least weekly over a period of more than two years. Linda includes a number of examples of “*anxiety, fear, depression*” in her story, but she felt that she was generally able to develop strategies to cope with these experiences before they disrupted her life in any serious way. The depression experience which came close to destroying her life related to her inability to have a sexual relationship with her husband without severe pain.

Linda is a well-educated woman, from a loving and supportive family. Although she was shy as an adult, she formed a number of close and enduring friendships with other women. Her Christian beliefs have always been important to her, and in her late twenties she met and fell in love with a man who shared those beliefs, and who was also highly educated and committed to a people-focused career. The difficulties in their sexual relationship and the consequent inability to have children resulted in a major strain on both of them, and on their relationship. Linda's husband joined with her in attempts to find a solution to their problem.

Finally, through the intervention of a friend, in whom she had confided about her despair, the frustration of therapy, and the misery of her marriage, Linda was referred through to a medical specialist who diagnosed a condition that could be cured with relatively minor surgery. When she reflected back on that discovery Linda said “*I think from about that point on I stopped feeling depressed. I don't remember having anything like the sort of black days I had.*”

Linda's generous spirit is revealed when she explains why she chose to take part in this project. At the time she was interviewed she was pregnant with her first child. She realised that had she not found the right help this would never have been possible, and she knew that her marriage would have probably ended. She believes that she needed to be proactive searching for solutions, and she wanted to encourage others to also be persistent, and honest. She believes that people need to question the solutions offered by professionals if they are finding them unhelpful. She said:

*the whole process of actually taking charge .... and trying to deal with a thing does make you reach the goal in the end. Because you become more competent at being able to know what it is that's wrong.*

## ***“Life is not to be enjoyed”***

The nine women I have just introduced all talked about their lives being disrupted by depression for relatively discreet periods of time. The remaining women talked of depression being part of their lives for long periods, in some cases from well before their birth. They often talk of developing coping and management skills so that their lives are less disrupted, even though depression still lurks around.

### **Kate**

Kate is the youngest of the participants; she was in her early thirties at the time of the interview. Like Hannah and Charlotte she had immigrated to New Zealand, with a male partner, when she was in her early to mid twenties. However, whereas the older women had moved country in the middle of the 20<sup>th</sup> century, Kate came in the more mobile nineties and has visited her home country more than once and also been visited by friends and close family members. She moved with her partner, and her relationship with him is very supportive and loving. They have chosen, thus far, to remain childless.

Kate is very clear about when depression first disrupted her life. She knows that neither she, nor anyone else recognised it, but believes it began when she was a child. She said: *“now I look back on it I realise that probably .... the depression started when my parents split up when I was ten”*. The “fugginess” that for her characterised her depression lasted for more than fifteen years and through a variety of attempts to blot out or cure her distress. Throughout her story Kate reveals her tenaciousness in continuing to seek solutions. She now lives a life of colour. The rooms in her house are painted turquoise, tangerine and yellow, and she talks about her newly acquired attitude to clothes:

*Even down to clothes. I always used to wear black. Always wore black. Because I couldn't cope with colours. I couldn't mix colours, I didn't want to wear colours.... like now, I don't actually even pick out black. I'll look at a red dress and a black dress, and I'll think ooo, I'll have the red one. Whereas I always used to buy everything in black.*

Kate's depression began in late childhood, and the years of serious disruption ended when she was about thirty, when she finally found a form of alternative therapy which worked for her. At the time she told her story she was rejoicing in having discovered a ‘normal’ state of living which she describes as:

*.... feeling clear, and feeling positive, and being happy. I mean - not like - I mean, I'd love to be joyously happy. I can't say that I'm joyously happy. But I have moments of joy. And, and on a day to day level, I'm very happy.*

### **Elizabeth**

Elizabeth told of a family history of mental health problems. Her father committed suicide, after spending many years under the care of a psychiatrist. She tells of her mother, her sister and her son all living with diagnosed mental health problems. Elizabeth relishes time on her own, whilst still greatly enjoying time with her partner, children and friends. She has a lively and enquiring mind, and describes herself as having *“always been someone who questioned things”*.

Central to Elizabeth's life now is her focus on "grace, soul and spirit". As part of her journey to self-understanding and learning to have a life less disrupted by depression she took a long holiday in Europe. She went without clear plans, and allowed herself to follow her instincts. She spoke of that time with deep appreciation:

*it was a really powerful time for me, .... getting in touch with, .... sort of spiritual things. I went to -- I mean churches found me, I didn't find churches. I would just, -- I -- every church I could find I was in. And it was a hugely uplifting time for me. And, realising that aspect of my life has been, .... that was the start of the journey.*

She talks of this experience as profound. When she returned to New Zealand she knew that her life had changed. She reflected on this, saying:

*I guess, starting to question about what I was doing with my life. --- and it all became so superficial --- everything that I had been doing. And I was earning thousands of dollars a year, you know --- unbelievable amount of money, and yet it meant nothing. So when I came back from this trip away --- I very nearly didn't come back, actually. It was a real sort of "Do I go this way, or do I go that way?"*

At this point she decided to re-train for a very different career, which was much more connected with her growing holistic understanding of her life. However, like all the women, Elizabeth is complex, and her story is multi-faceted. She talks of depression still being a part of her life, but she is no longer overwhelmed by it. She knows things she can do which will lessen its impact, and she has learned to not only develop the metaphysical understanding of her life, but also to consciously be open about her experiences, however bad they may be. She seeks out friends and some family members to talk with whenever that seems appropriate.

## **Marge**

Six of the women had moved to live in New Zealand as adults. Marge was one of these. She came here as an adult in her early thirties, to follow up a job opportunity with an international company. Marge is very clear that her depression is closely linked to paid work. She said the issue of paid employment was:

*really big, and this will come up throughout my whole series of depression, it had to do with work. Work was a very big problem (laughs awkwardly) ... in my life.*

Marge told her story in a very thoughtful and self-reflective way. She planned what she wanted to say before I arrived, and at the end of the interview checked with her notes to make sure she had covered all the things she wanted me to know. She was very clear about which parts of her life and experience were relevant to the story of her life with depression and which parts weren't. So, at one point in the interview she mentioned something about her childhood and then stopped, saying – "anyway, I don't have to tell you all the details of my life". This statement did not sound like a lack of trust in me, as someone to share with, but more like a clear understanding about detail that belonged in this narrative of depression and Marge.

We had the interview in Marge's home, in the company of her cat, and she acknowledged the importance of her passion and pets in her life. She explained:

*Following my heart. .... I really had to learn how to follow my heart rather than following my head. What I should do. And kind of allowing some of my passions to kind of be recognized, I suppose. Like I do have a passion for animals, my cats, I've got one more round here somewhere, are really important to me ....*

In her narrative Marge honours the emotional and practical support she receives from her partner. Marge lives a life which involves her heart: she talks warmly of relationships with friends and also of her own sensitive caring for people with particular needs.

## **Ruth**

Ruth was in her early fifties when I interviewed her. She had grown up children, and had a successful people-oriented career. She had left a violent marriage in her early adulthood, and was now in an established second marriage, which was characterised by good communication and love. Ruth talked of herself as having a “*highly developed sensual system*” which gives her insight into others that some people have referred to as her being a ‘witch’. She values this extra ability to “*pick up information*” around her, but believes that this has also linked in to her vulnerability to depression. She saw the same abilities in her grandmother, and other members of the family recognised it in her.

Ruth said she knew at this time that that depression would always be a part of her life. She managed it with a wide range of things, including therapy, medication, exercise and healthy eating. However, she recognised that for her depression is an “*old friend that's very useful. But when it takes over it is just awful.*” Ruth has studied herself and the way that depression can disrupt her life. She believes that at the time she shared her story she was able to monitor it in some detail, and take responsibility for making adjustments to her life. She said:

*So the problems I have now, are to do with trusting myself enough to be able to go with what I put together. And if I don't put the right things together for myself, I start eating irritably I mean I eat heaps. But I know that food, certain food, at certain times can trigger off low feelings. Like too much coffee, too much meat, and things like that. And so if I go on a binge .... I absolutely know that I'm going to get hit, and the way it comes out in me more than anything is migraine, and I used to get clusters a lot ten years ago, but now I've got it down to probably two last year. And that's through diet, and exercise and understanding the lowness, or getting it together. Like if I'm starting to feel low I think “Right - this is what I've got to do”. And if I don't do it it's my own fault. Really.*

Ruth talks about the importance of having the right friends more than most of the other women who took part in this project. She values mostly women friends whom she can talk with about many aspects of life, including the metaphysical. At one point in the interview she said in relation to a particular friend: “*My God, thank God I've got someone to talk to about it.*”

## Karen

Karen told her story when she was in her fifties. Depression had disrupted about fifteen years of her life in a major way. It was worst from her adolescence through into her early adulthood. Features of the disruption had been times of hospitalisation and the experience of many medical interventions including a range of medication and ECT. She has made use of varying forms of therapy throughout her life. She increasingly used therapy in a way that was well informed by her ever growing wisdom about her self and her knowledge of available resources. Her vulnerability to depression was linked with the disabling condition which had impacted on her to different degrees for most of her life.

Karen brought to the telling of her story her fine intellect, her wry sense of humour and her passion for social justice. She also has a strong creative side which shows itself in a love of music, of literature and of a wide range of intellectual and academic interests. She has a strong commitment to community, to her husband of many years, to her extended family and to her beliefs. In order to live as well as possible with her disability she has also needed to develop a strong ability to plan and to organise her life in very practical ways.

At one point in the interview, Karen talked of the creature she feels closest to. She said:

*an elephant is the one .... I really identified, over and over again, I listened "An elephant's life is tedious, laborious, and slow. I've been an elephant all my life, so I blooming well ought to know." (singing) and then it talks about "So I'll stay in the elephant's nursing home, - -- " and its amazing. Its so apposite, not that I did it of course consciously, but of course there always is some degree of consciousness. Oh I think so. I wouldn't want to say it was all unconscious. So I think I identified with the elephant and I do have similarities --- Yeah, the sort of slowness and that, the kind of maternal focus of culture about it.*

*JAN: And the grandness?*

*KAREN: Yes. Yes. Awesome. Awesome creatures. Yeah, so there was lots for me in the elephant. And I could really relate to that as a creature. And it helped a lot.*

## Chloe

Chloe, Anne and Hine are the next three women I will introduce. They have all included in their narratives significant experiences of violence and/or neglect during their childhood. They connect these early experiences with the intrusion of depression into their lives. By the time they shared their stories, however, they had all created for themselves lives without violence or abuse. In fact, they were all amongst the group of eight participants who identified as working in the area of therapy, counselling or social work.

Chloe revealed herself as a creative woman, who wrote poetry, and often kept a journal. She endured a number of unsatisfactory, and at times violent, relationships in her early adult life. However, she finally found the right partner, had children, and developed a new, fulfilling career. In the course of training she experienced what she referred to as 'bliss'. She discusses this concept in the following passage:

*as this sort of deepening process....happened, so too did a more ..., and, and my counselor was very into this too. Starting more of the*



*spiritual dimension. Became very aware of it. Because the bliss, I thought, is this the bliss? I know the bliss, this is it. This is what it means to be connected with the divine, this is it. I've seen it, I know it. And so, yeah, I had a hope. And so that became a huge part of the journey, so I went into all the women's the archetypes for women, and oh, the body stories. All that. Huge richness that I didn't even know existed. And to be able to sort of see it in myself and in the world. And the connection just with being on the planet really. The seasons, and the training groups were really powerful for me too. Very, encouraging of just being. Just, whoever we happened to be at that particular time, and I just got right into it, I was just in the right place. I knew this was exactly ...*

## **Anne**

At the time she shared her story, Anne was in her forties and the mother of two teenagers, who were living with her most of the time, but also were in regular contact with their father. She was a full-time therapist, and had a strong interest in the creative arts and in astrology. Anne had come from a family in which the siblings became very close, but where there had been many experiences of her parenting that was inadequate and parents who were often unavailable as the children grew up.

Anne compared her childhood with that of her own children, and at one point she highlighted how she had been able to do it differently. She said:

*there's a lot more laughter in our house and craziness and things like that instead of pitter-pattering little feet trying to keep Mum on an even keel the way I used to, because I did breed two very sensitive little darlings both very much little sea anemones just like me. So I'm very aware when I see the sucking back process and then I can make an approach to counteract that. .... It's a huge difference because we [Anne and her siblings] never got met. We just stayed on the outside. If you were sent out in disgrace well you felt alienated by their emotional behaviour. Nobody ever came to meet you so that wasn't a process. The gap being closed was never part of our experience - - always a big space just sometimes bigger than others.*

Anne's ability to do it differently was told partly in the context of some significant mentors in her life, especially during her late teens and early twenties. She had considerable creative talent, and this was recognised by adults from outside her family. While she was still at school she was supported by one of her teachers, who gave her space and encouragement to do her creative work. She says of this time, and this relationship *"I felt the experience of home for the first time."*

## **Hine**

Hine, like Anne and Chloe had experiences of violence in her early life. She was exposed to domestic violence and sexual abuse. However, as a young Māori growing up in the latter part of the twentieth century she also experienced the impact of colonisation. She reflected that until she was in her early thirties she had no idea that there were choices available to her.

*I didn't understand that there was any choice for me. I thought that I had three children, I didn't have an education, I didn't have a career, I was lesbian, Māori, on a benefit, couldn't drive a car and*

*that was to do with my dissociation which happened as a result of a sexual assault as a 12 year old,*

In her narrative, Hine acknowledges that her resilience has stemmed, in part at least, from her always being 'bright'. Finally she was advised, in her thirties, to pursue a university level education. She has flourished in this academic environment. Before she found these opportunities for development and fulfilment, Hine had suffered greatly from depression, anger and isolation. She had experienced time in a psychiatric hospital, some unhelpful and possibly dangerous medication and times of feeling very suicidal.

Hine emerged from these disrupted years with a strong sense of her 'god-self' and her 'good-self'. With a belief in her own ability to know what was right for herself. She suggested that this was a knowledge worth sharing with other women:

*.... trust your instinct. Trust your own women's energy. Listen to that before you listen to your GP's or your counsellor's or your mother's or your husband's or your lover's or your lesbian partner or whoever. Trust your own wisdom because that is right for you and everybody - I believe everybody is divine, so everybody's wisdom and knowledge is made just right for them.*

## **Naomi**

Naomi's narrative goes furthest back into the past in telling the beginnings of her life disrupted by depression. Where Hine alluded to the impact of colonisation, Naomi refers specifically to the holocaust. She is a Jewish woman, and was about 40 years old at the time of the interview. She was living on her own with her one teenage child. Naomi is one of the adult immigrant women in this project. She had moved around the world in her adult life, trying to find a place where life could have meaning for her. In the process, she had become involved in a violent relationship, and had fled from that to New Zealand.

In her narrative Naomi strongly acknowledges the embodied nature of depression. She frequently reflects on the connection, for her, between actions and feelings and her awareness, or separation from, her own body. At the worst times of depression she describes herself as being a "zombie", having a "numbness" that made her one of the "living dead". As she healed, she luxuriated in the sun on the beaches, the warmth of soaking in hot pools and saw these experiences as 'thawing' her out. Hers was a long journey of recovery from the worst disruption of depression. As for all the women in this latter half of the chapter, Naomi feels that depression will always be a part of her life – but one that she is learning to manage. When she talks of how she came to have depression in her life she says she grew up with:

*the script of – "I am in this world to suffer. I am in this world to repent." Which is all holocaust --- not only, some stuff just from the family. You know, you don't enjoy, life is not to be enjoyed. This is the message that I've had from day one. That --- and all my history, my ancestry. Its sort of life is not to be enjoyed, life is to be endured, and because I'm born in a time of peace, where I'm not fighting for my life, I need to find ways to fight for my life anyway. Because that's the way it is. You, you just don't exist without that ....*

## ***APPENDIX G***

### **Interview Outline**

## **WOMEN AND DEPRESSION**

### **Interview – Brief Outline**

The interview will very much follow the flow of each woman's individual story of her life with and beyond the serious disruption of depression. *She will be invited to tell, in her own words, how depression came into her life, how her life was disrupted as a result, and how it happened that she is now living a life without depression causing major disruption.* However, responses to the following questions need to be incorporated.

#### **Questions to be covered at some time in the interview.**

How did you come to use the word depression for what was happening in your life?

Do you have any ideas about how or why depression came into your life?

How was your life at the worst times with depression? What could you do? How were you treated by others? What did you think was happening?

Was there a particular time, or stage in your life when you noticed depression was less disruptive? When your life was beginning to improve?

How is your life now?

Is depression still a part of your life from time to time?

Have you found different ways of living that make your life less disrupted?

What things or people or actions or thoughts have helped you in this change for the better?

Did anything or anyone make this change and progress more difficult?

Do you feel there are any things about you which made it possible for depression to disrupt your life, but then let you find a way to restore your life?

#### **At the end of the interview.**

Do you feel you have told your story to your satisfaction?

Is there anything else you would like to add?

Do you have a name you would like me to use when referring to your story?

I will thank each woman for her participation, ensure that she has support if she finds herself distressed, and remind her that I would like to contact her within the following week to check how she is, and to ask any questions I may have left out, check anything I have not understood, and let her tell anything she left out of the interview.

## ***APPENDIX H***

### **Individual Interview Consent Form**



Faculty of Arts & Social Sciences  
Te Kura Kete Aronui  
The University of Waikato  
Private Bag 3105  
Hamilton, New Zealand

Department of Sociology and Social  
Policy

Women's & Gender Studies Programme

Telephone 64-7-838 4718  
Facsimile 64-7-838 4258  
Email caro@waikato.ac.nz  
<http://www.waikato.ac.nz/sass/>



The  
University  
of Waikato  
Te Whare Wānanga  
o Waikato

## WOMEN AND DEPRESSION

### CONSENT FORM -Researcher's Copy

I have received and read a copy of the information sheet for this project and the researcher has also discussed the process of the research with me.

I have had any current questions answered by the researcher and feel satisfied with that information. I know that I am able to ask further questions throughout the process of the research. I am aware that I am able to cease my involvement in the research at any time, without giving a reason.

I have had time to consider my involvement in this research. I understand that taking part in this research is voluntary (my choice).

I consent to my interview being audio tape recorded. I am aware that I can ask for any information to be deleted from the tape recorded interview. I am aware that I can ensure that any potentially identifying information can be altered or changed or removed from the transcript of the interview. I can request these changes at any time. I feel comfortable in making any such request in the knowledge that I have rights of access to my information, and that I am giving this information voluntarily.

I am aware that the audio tape recordings and verbatim transcripts, generated in discussion with me will remain confidential. The edited transcript with identifying features removed will be shared with the researcher's supervisors. I will be consulted about the use of any personal information which may reveal my identity and reserve the right to deny the use of this information.

By signing this consent form I agree to take part in the project and give permission for the researcher to use the material generated by me in the interview. Information will be used by the researcher for the primary purpose of completing a thesis for a PhD on Women and Depression. Data may also be used by the researcher and/or her supervisors for other scholarly articles or conference presentations.

I know that I can raise any concerns about how the interview material is used or any issues related to the project to the researcher or her supervisors, whose names and

addresses are listed below. Should the need arise I know I can make a formal complaint to the University of Waikato, Deputy Vice Chancellor, Phone 07 856 2889.

Signed: \_\_\_\_\_ (participant)

Signed: \_\_\_\_\_ (researcher)

### Names and Contact Addresses of Researcher and Supervisors.

**Researcher:** Jan Wilson  
Women's and Gender Studies  
Department of Sociology and Social Policy  
University of Waikato  
Private Bag 3105  
HAMILTON

**Supervisors:** Dr Hilary Lapsley  
Women's and Gender Studies  
Department of Sociology and Social Policy  
University of Waikato  
Private Bag 3105  
HAMILTON

Professor Jane Ritchie  
Department of Psychology  
University of Waikato  
Private Bag 3105  
HAMILTON



## ***APPENDIX I***

### **Consent Form for Group Participants**



addresses are listed below. Should the need arise, a formal complaint to the University of Waikato, Department of Sociology and Social Policy, Private Bag 3105, Hamilton, New Zealand, can be made.

Signed: \_\_\_\_\_

Signed: \_\_\_\_\_

Names and Contact Addresses of Researcher and Supervisors

Faculty of Arts & Social Sciences

Te Kura Kete Aronui

The University of Waikato

Private Bag 3105

Hamilton, New Zealand

Department of Sociology and Social Policy

Women's & Gender Studies Programme

Telephone 64-7-838 4718

Facsimile 64-7-838 4258

Email caro@waikato.ac.nz

<http://www.waikato.ac.nz/sass/>



The  
University  
of Waikato  
Te Whare Wānanga  
o Waikato

## WOMEN AND DEPRESSION

Researcher: Jan Wilson

### CONSENT FORM -Participant's Copy

Department of Sociology and Social Policy  
University of Waikato

I have received and read a copy of the information sheet for this project and the researcher has also discussed the process of the research with me.

I have had any current questions answered by the researcher and feel satisfied with that information. I know that I am able to ask further questions throughout the process of the research. I am aware that I am able to cease my involvement in the research at any time, without giving a reason.

I have had time to consider my involvement in this research. I understand that taking part in this research is voluntary (my choice).

I consent to the group discussion being audio tape recorded. I am aware that I can ask for any information to be deleted from the tape recorded discussion. I am aware that I can ensure that any potentially identifying information can be altered or changed or removed from the transcript. I can request these changes at any time. I feel comfortable in making any such request in the knowledge that I have rights of access to my information, and that I am giving this information voluntarily.

I am aware that the audio tape recordings and verbatim transcripts, generated in discussion with me will remain confidential. The edited transcript with identifying features removed will be shared with the researcher's supervisors. I will be consulted about the use of any personal information which may reveal my identity and reserve the right to deny the use of this information.

By signing this consent form I agree to take part in the project and give permission for the researcher to use the material generated by me in the group discussion. Information will be used by the researcher for the primary purpose of completing a thesis for a PhD on Women and Depression. Data may also be used by the researcher and/or her supervisors for other scholarly articles or conference presentations.

I know that I can raise any concerns about how the discussion material is used or any issues related to the project to the researcher or her supervisors, whose names and

addresses are listed below. Should the need arise I know I can make a formal complaint to the University of Waikato, Deputy Vice Chancellor, Phone 07 856 2889.

Signed: \_\_\_\_\_ (participant)

Signed: Jan Wilson (researcher)

### Names and Contact Addresses of Researcher and Supervisors.

**Researcher:** Jan Wilson  
Women's and Gender Studies  
Department of Sociology and Social Policy  
University of Waikato  
Private Bag 3105  
HAMILTON

**Supervisors:** Dr Hilary Lapsley  
Women's and Gender Studies  
Department of Sociology and Social Policy  
University of Waikato  
Private Bag 3105  
HAMILTON

Professor Jane Ritchie  
Department of Psychology  
University of Waikato  
Private Bag 3105  
HAMILTON

I am aware that the audio tape recordings and verbatim transcripts, generated in discussion with me will remain confidential. The edited transcript with identifying features removed will be shared with the researcher's supervisors. I will be consulted about the use of any personal information which may reveal my identity and reserve the right to deny the use of this information.

By signing this consent form I agree to take part in the project and give permission for the researcher to use the material generated by me in the group discussion. Information will be used by the researcher for the primary purpose of completing a thesis for a PhD on Women and Depression. Data may also be used by the researcher and/or her supervisors for other scholarly articles or conference presentations.

I know that I can raise any concerns about how the discussion material is used or any issues related to the project to the researcher or her supervisors, whose names and

## ***APPENDIX J***

### **Notes for Participants in Group Discussion**



## **WOMEN'S JOURNEYS THROUGH AND BEYOND DEPRESSION.**

### **Notes for potential participants in group discussions.**

I have prepared these notes as a discussion document for those women who:

- have already participated in this project by telling the story of their own journey through depression
- are trained and/or practising counsellors or therapists
- have expressed a willingness to consider taking part in group discussions about recovery from depression.

#### What do I hope to achieve from the group meetings ?

Individual interviews with you and your peers have provided a wealth of wisdom about the different experiences of 18 women whose lives have been disrupted by an experience of depression. The stories provide valuable understandings of ways to reduce disruption and to move into recovery. All the women I have talked with have incorporated into their journeys a variety of non-professional ideas, wisdom and activities. Some have also found help from different kinds of medication or from counselling or therapy.

I am hoping that the group discussions will elaborate on some of the issues that have arisen during the individual interviews. As a group we may be able to understand in a different way some of the themes and possibilities that have emerged from the earlier interviews. Although my analysis of those interviews has barely begun, some interesting issues are emerging, and I value the opportunity to discuss them with you.

Some of the things I wonder about are:

- Are there connections between the story of how depression came into each woman's life and the story of how they moved beyond the major disruption of depression?
- How does gender (being a woman) relate to the experience of depression?
- What are the interactions, if any, between professional and lay wisdom about the development, maintenance and recovery from the experience of depression?
- What words do you choose to use about your experience of depression? Do you understand depression as a 'mental disorder', a 'disabling mental health problem' or a time of 'mental ill health' or would you use some other language ?
- How has the experience of 'being depressed' informed your work as a counsellor?
- How has being a counsellor influenced the way you have 'handled' your experience of depression?

PLEASE COMPLETE THE FORM ON THE NEXT TWO PAGES, AND RETURN TO ME IN THE STAMPED ADDRESSED ENVELOPE.



## QUESTIONNAIRE TO HELP ME ORGANISE THE GROUP MEETINGS.

Please contact me by telephone (410 9508) or e-mail ([jan.wilson@aut.ac.nz](mailto:jan.wilson@aut.ac.nz)) if you need to discuss anything about the group meetings.

### What would you like to have discussed in the group?

---

---

---

---

---

---

---

---

---

---

---

---

5. Would it be suitable for you to meet at Akoranga Campus of AUT?

### Date of Meetings

1. Are there any days in October and November when you will not be available at all?

6. If AUT were not available, would you be able to come to my home in Milford for meetings?

---

---

---

### Length of Meetings

7. Are you able to attend a meeting for 1 1/2 to 2 hours?

2. Are there dates in October and November which you would prefer?

---

---

---

### Number of Meetings

8. I have suggested we have 2 or 3 meetings. How many meetings would you be able to attend?

---

---

### **Days and Times for Meetings**

3. Are there any days and times when you would not be available?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. Are there days and times which you would prefer?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### **Venue**

5. Would it be suitable for you to meet at Akoranga Campus of AUT ?

\_\_\_\_\_

6. If AUT were not available, would you be able to come to my home in Milford for meetings?

\_\_\_\_\_

### **Length of Meetings**

7. Are you able to attend a meeting for 1 ½ to 2 hours?

\_\_\_\_\_

### **Number of Meetings**

8. I have suggested we have 2 or 3 meetings. How many meetings would you be able to attend?

\_\_\_\_\_



## WOMEN'S JOURNEYS THROUGH AND BEYOND DEPRESSION

### Comments and Questions

Do you have any other comments or questions about this group, and the 'nuts and bolts' arrangements?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What do I hope to achieve from the group meetings?

\_\_\_\_\_

Individual interviews with you and your peers have provided a wealth of information about the different experiences of 10 women whose lives have been disrupted by an experience of depression. The stories provide valuable understandings of ways to reduce disruption and to move into recovery. All the women I have talked with have incorporated into their journeys a variety of professional advice, wisdom and resources. Some have also found help from different kinds of medication or from counselling or therapy.

I am hoping that the group discussions will elaborate on some of the issues that have arisen during the individual interviews. As a group we may be able to understand in a different way some of the themes and possibilities that have emerged from the earlier interviews. Although my analysis of those interviews has barely begun, some interesting issues are emerging, and I value the opportunity to discuss them with you.

Some of the things I wonder about are:

- a. Are there connections between the story of how depression came into each woman's life and the story of how they moved beyond the major disruption of depression?
- b. How does gender (being a woman) relate to the experience of depression?
- c. What are the interactions, if any, between professional and lay wisdom about the development, maintenance and recovery from the experience of depression?
- d. What words do you choose to use about your experience of depression? Do you understand depression as a 'mental disorder', a 'debilitating mental health problem' or a time of 'mental ill health' or would you use some other language?
- e. How has the experience of 'being depressed' informed your work as a counsellor?
- f. How has being a counsellor influenced the way you have handled your experience of depression?

## ***APPENDIX K***

### **Women's feedback for Group Discussion**



**Counsellor Group – Feedback from organizational questionnaire.**  
**October 2000**

Potential group members were asked to answer the following question before the group met.

*What would you like to have discussed in the group?*

The responses were as follows:

- Different therapeutic modalities which have been helpful in treating depression.
- Women and depression.
- Connection between depression and cultural issues – e.g. displacement, migration, colonization etc.
- Connection between depression and addictions and what helps – or not.
- Connections between the stories and how gender is inclusive in this.
- I am also aware that the medical/health language around depression absolutely did not fit my experience (nor did the isolating in an outpatient capacity in a mental health clinic) – the language of spirituality, connection with 'God' and beingness is much more in keeping with the huge sense of loss depression was for me.
- I am flexible about this , but I would like to explore in more depth your point 4 ( "words used for depression" do you understand depression as a 'mental disorder' etc.) Depression I believe is a state of being. It can become a mental illness when one can no longer function without being dependent on others, long or short term etc.

## ***APPENDIX L***

### **Agenda for Group Meeting One and Memory Work Introduction**

## **Womens Journeys through and Beyond Depression.**

### **Group meetings of counsellor participants.**

#### **Meeting One**

**Date: November 1<sup>st</sup>, 2000**

#### **AIMS**

- 1. To introduce ourselves to each other.**
- 2. To establish roles of myself, Hilary, other participants.**
- 3. To establish ground rules.**
- 4. To establish reasonable trust and rapport.**
- 5. To begin to share experiences of 'recovery' from depression.**
- 6. To establish goals and topics for this and future meetings.**

#### **'PROGRAMME':**

- 1. Explain the role that I expect to take in the group. i.e. facilitator more than participant, but without barring myself from joining discussion.**
- 2. 'Nuts and bolts' ; Time frame, supper, toilets, phone, parking, etc.**
- 3. Introduce Hilary as assistant facilitator. Allow her to explain her role and her interest in this project. —**
- 4. Discuss and clarify any formal 'ground rules' that the group may need.**  
This needs to include the formal signing of consent forms, and establishment of protocol around audio-taping.
- 5. Introductions: each woman to introduce herself, and talk about the second topic raised in the preliminary notes:**  
*...the factors involved in deciding to be a part of this research project and a part of this group of counsellors who have experienced depression.*
- 6. Participants share a 'key to recovery' as outlined in the notes distributed before the group.**  
*"Sharing a memory, symbol, story, painting, piece of music, novel, place or anything else which represents for you a key to your recovery from the worst disruption of depression."*



**(N.B. the group will be invited to decide whether to move on to this focus for discussion, or to first look at the feedback sheet, at other interests, and at apportioning time to these interests in this and following group meetings)**

7. To distribute the 'feedback' sheet, and decide together on how to use the rest of this first meeting.
8. Decide about the topics for discussion at this and future meetings. Prioritise.
9. Organise a third meeting time and place. Discuss contact between meetings.
10. Closure – invite suggestions.

#### NOTES:

As much as possible focus on personal experience (i.e. not just the participant's client's stories). I need to make this goal clear early in the first session. That the interest continues to lie with personal experiences with depression, although that will be informed by counselling training, practice and experience.

## ***APPENDIX M***

### **Explanation of Memory Work**



## A POSSIBLE GROUP ACTIVITY – An adaptation of 'memory-work'.

I have written this brief explanation of a method we might possibly use to explore some issues about 'journeys through depression'.

**ADAPTED MEMORY WORK:** Exploring an experience related to recovery from depression. (Maybe hope, or another trigger we decide on as a group)

### An Introduction (brief!) to memory-work?

Memory-work was developed in the 1980s by Frigga Haug, a German feminist and scholar. A group of five Australian women used the method to explore emotions, and published their account of this work in 1992.<sup>1</sup> The following brief explanation of the purposes and process of 'memory-work' is drawn from this book, as are the examples of 'memories'.

"The underlying theory is that subjectively significant events, events which are remembered, and they way they are subsequently constructed, play an important part in the construction of self. Because self is socially constructed through reflection, Haug's theory dictates memory-work as method. The initial data of the method, memory-work, are memories, which are reappraised collectively to uncover and document the social nature of their production." (p 37)

The Australian women decided to explore memory-work because they were dissatisfied with research methods commonly used in the social sciences. They felt alienated from academic psychology, feeling it "supported the pervasive oppression of women in our society". They wanted to explore alternative methodologies that could work in understanding better such issues as oppression and racism, as well as emotions. They wanted to transcend traditional boundaries and distinctions between disciplines such as psychology and sociology. They wanted to acknowledge that "experience itself is a resource; that it can and indeed should be acknowledged as the basis of theory and research." (pp3-4)

The work involves the production of written memories, written in the third person, and triggered by a topic such as 'fear' or 'saying sorry' or 'holidays'. However it is important to note that: "We are working with memories not events. We assume that each memory refers to some real event in time. But the memory is a construction of that even, a construction that changes with reflection, and over time. It is the construction that we are interested in, not the event, because the construction tells us something about the way the person relates to the social. Furthermore, we assume that we continually reconstruct our memories as we find new or different or more satisfying meanings according to our later life experiences and the changing social order in which we live. We retrospectively shed new light on old events; we reinterpret old events from new knowledge. We note for example the effect of

<sup>1</sup> Crawford, June, Kippax, Susan, Onyx, Jenny, Gault, Una and Benton, Pam. (1992). *Emotion and Gender: Constructing Meaning from Memory*. London: Sage.

the women's movement on our changing consciousness of childhood events. We assume that this process of memory reconstruction continues throughout our lifetime." (p8) "the memories are about us as individuals, they also say much about the social order in which we constitute ourselves. This is particularly so when the language we choose is the clichéd language of the mundane. This language provides insights into the moral order of our social world; by deconstructing the language of clichés we may get at some of the underlying unquestioned assumptions of that moral order." (p9)

### How do you Do Memory-Work?

First you need a group, a group such as we have set up to consider issues around women's experience of depression and recovery. In its pure form 'memory-work' is carried out as a collective and consists of three phases:

#### *Phase One*

*The production of the written memories. If we decide to use this approach, we could follow the following rules, but with a lot of flexibility. For example I do not think we need to rewrite the memories as suggested in Phase Two (6):*

1. Write a memory
2. of a particular episode, action or event
3. in the third person
4. in as much detail as is possible, including even 'inconsequential' or trivial detail (it may be helpful to think of a key image, sound, taste, smell, touch)
5. but without importing interpretation, explanation or biography.

#### *Phase Two*

Having written their memories the co-researchers meet to read and analyse all the memories. The rules or guidelines for this phase are:

1. Each memory-work group member expresses opinions and ideas about each memory in turn, and
2. looks for similarities and differences between the memories and looks for continuous elements among memories whose relation to each other is not immediately apparent. Each member should question particularly those aspects of the events which do not appear amenable to comparison. She or he should not, however, resort to autobiography or biography.
3. Each memory-work member identifies clichés, generalizations, contradictions, cultural imperatives, metaphor ... And
4. discusses theories, popular conceptions, sayings and images about the topic.
5. Finally, each member examines what is not written in the memories (but what might be expected to be), and
6. rewrites the memories. (p49)

The issue about biography and autobiography is that the interest is not why X's father did such and such but why fathers do such things.



### Phase Three

The material provided in Phases 1 and 2 is examined and further theorized, it may be that the themes are examined in the light of 'accepted' theories, or common assumptions about the topic. They might be discussed in the light of 'gender' theory or assumptions, or in terms of different 'psychological' or 'counselling' theoretical positions. Perhaps looking at 'narrative', 'psycho-dynamic' and 'cognitive-behavioural' theories, as well as 'lay' theories.

Examples of Written Memories- (these are taken from the Kippax and Crawford book).

### Happiness

She was 4 years old. Her mother was in hospital giving birth to her baby brother. She was alone with her father. He gave her a bath, using a large baby bath on the kitchen table. She didn't know why he wasn't using the big bath in the bathroom. He made a game of it, and she enjoyed it mildly. Then she stood up to get out of the bath. Her father held out a towel in his arms and told her to jump into it. She was slightly afraid, slightly exhilarated. She jumped into his arms and knew complete security and happiness.

She led Tandi to the saddle shed, saddled up, mounted and started off up the bright green grass-covered paddock, past the dam where a few ducks and pigs were feeding to the 'top' gate – the sense of excitement and joy as the horse and she cantered on across the landscape was a deeply felt experience which is a pleasure to recall now – feelings of freedom, floating, unity, trust, and sheer joy were all present.

### The beginning of an adult holiday

Marie arrived with the family at Durras lake. They were to stay for a week, quite a mob of adults and children. There would be a lot of noise and activity. Yet the attraction of the place, for Marie, was the peace of the beach and the bush. As soon as possible she left the others and walked down to the beach with W. It looked so inviting, the lake, the sea, long stretch of beach in the late afternoon .... Leaving the kids behind. Just walking to the sound of the surf and the wind in her face. Not talking much. No hurry. Marvellous sense of release and freedom. The promise of empty days.

### A Memory from later in the same holiday

On the day in question the group looked to Marie to organize the day's outings (as usual). It was a glorious day so Marie suggested the group spend the morning swimming in the lake (lagoon) below. Then after a light lunch they could go exploring down the coast. The morning went well. By late morning R discovered fish near where he had been swimming. J and C quickly joined him with fishing lines. By the time they quit for lunch it was .....too late to go anywhere. Marie felt hurt and angry

and cheated of her turn. The family had always been careful to .... Give everyone a turn, an opportunity for a treat or outing. But with the two outside males .... the balance had been tipped. Marie was outnumbered and her wishes ignored. She hated fishing and yet had graciously given up two precious days. Now she stormed out of the hut and off down the beach, seeking solitude to express her rage and hurt- shouting at the waves 'the bastards' .... it's my holiday, I'm paying for the hut, my boat .... and I'm supposed to serve their bloody dinner .....

### If we agree to try this in the group it would probably happen in a third meeting.

What I would like to do, is have a go at this three phase process. This would mean us each bringing a written memory – in the third person – using the rules of Phase One. We would use a trigger that we agree to at the second meeting.  
I could be part of the group, and bring my memory, or I could just do the facilitation.

## ***APPENDIX N***

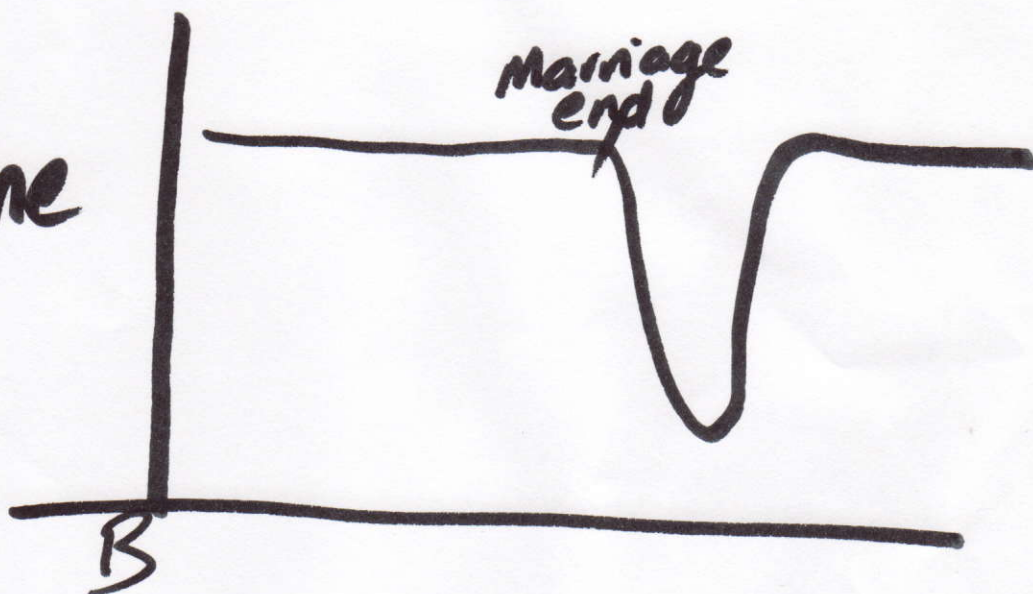
### **Graphical representations of depression journeys, based on Tuval-Maschiac**



Christine

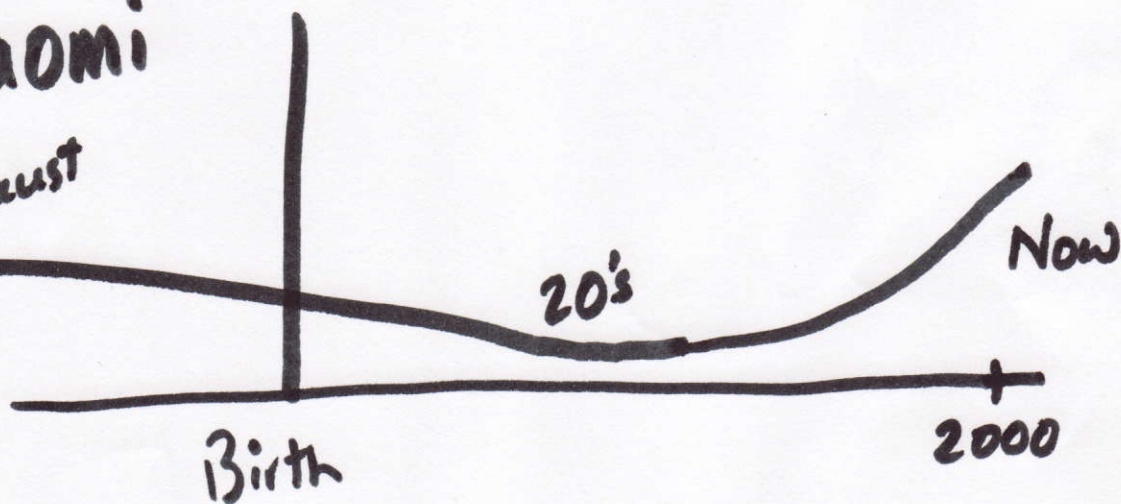


Jane



Naomi

holocaust



## ***APPENDIX O***

### **Example of N-Vivo Codes**

NVivo revision 2.0.161 Licensee: Bigbyte

Project: Chocolate stories User: Jandwilson Date: 26/02/2007 -  
8:11:57 PM

#### NODE LISTING

Nodes in Set: All Nodes  
Created: 30/03/2002 - 9:41:01 PM  
Modified: 30/03/2002 - 9:41:01 PM  
Number of Nodes: 234

- 1 Useful Quotes General
- 2 Useful Quotes~ Pre-onset
- 3 (1) /Experiences - impact
- 4 (1 1) /Experiences - impact/traumatic
- 5 (1 2) /Experiences - impact/supportive
- 6 (1 3) /Experiences - impact/limiting
- 7 (2) /Journey stage
- 8 (2 1) /Journey stage/Pre onset time
- 9 (2 3) /Journey stage/depression
- 10 (2 3 2) /Journey stage/depression/Early onset
- 11 (2 3 4) /Journey stage/depression/Seeking solutions
- 12 (2 5) /Journey stage/Manageable
- 13 (2 5 1) /Journey stage/Manageable/Constant monitoring
- 14 (2 5 2) /Journey stage/Manageable/Occasional monitoring
- 15 (2 5 3) /Journey stage/Manageable/No monitoring
- 16 (2 6) /Journey stage/Disruption
- 17 (3) /Life stage
- 18 (3 1) /Life stage/Pre-birth
- 19 (3 3) /Life stage/Childhood
- 20 (3 4) /Life stage/Adolescence
- 21 (3 5) /Life stage/Adulthood
- 22 (4) /People
- 23 (4 1) /People/Family
- 24 (4 1 1) /People/Family/children
- 25 (4 1 2) /People/Family/partner
- 26 (4 1 5) /People/Family/parents
- 27 (4 1 6) /People/Family/siblings
- 28 (4 2) /People/Friends
- 29 (4 3) /People/mentors
- 30 (4 4) /People/health professionals
- 31 (4 4 1) /People/health professionals/medical
- 32 (4 4 2) /People/health professionals/psychological
- 33 (4 4 3) /People/health professionals/alternative
- 34 (4 4 3 1) /People/health  
professionals/alternative/massage
- 35 (4 4 3 2) /People/health  
professionals/alternative/homeopathy
- 36 (4 4 3 3) /People/health  
professionals/alternative/spiritualism

37 (4 4 3 4) /People/health  
 professionals/alternative/witches  
 38 (4 5) /People/pets  
 39 (5) /Experiences - nature  
 40 (5 1) /Experiences - nature/marginalisation  
 41 (5 2) /Experiences - nature/death  
 42 (5 3) /Experiences - nature/divorce  
 43 (5 4) /Experiences - nature/accident  
 44 (5 5) /Experiences - nature/institutionalisation  
 45 (5 6) /Experiences - nature/colonisation  
 46 (5 7) /Experiences - nature/physical abuse  
 47 (5 8) /Experiences - nature/sexual abuse  
 48 (5 9) /Experiences - nature/emotional abuse  
 49 (5 10) /Experiences - nature/narrow-minded  
 50 (5 11) /Experiences - nature/authoritarian  
 51 (5 12) /Experiences - nature/loving  
 52 (5 13) /Experiences - nature/reassuring  
 53 (5 14) /Experiences - nature/affirming  
 54 (5 15) /Experiences - nature/understanding  
 55 (5 16) /Experiences - nature/emotional neglect  
 56 (5 17) /Experiences - nature/practically adequate  
 57 (5 18) /Experiences - nature/loss  
 58 (6) /Sense of Self  
 59 (6 1) /Sense of Self/Positive  
 60 (6 1 1) /Sense of Self/Positive/Fulfilled  
 61 (6 1 2) /Sense of Self/Positive/Clever  
 62 (6 1 3) /Sense of Self/Positive/Talented  
 63 (6 1 4) /Sense of Self/Positive/Friendly  
 64 (6 1 5) /Sense of Self/Positive/Educated  
 65 (6 1 6) /Sense of Self/Positive/Loveable  
 66 (6 1 7) /Sense of Self/Positive/Sexually attractive  
 67 (6 2) /Sense of Self/Negative  
 68 (6 2 1) /Sense of Self/Negative/Thick  
 69 (6 2 2) /Sense of Self/Negative/Uneducated  
 70 (6 2 3) /Sense of Self/Negative/Unlovable  
 71 (6 2 4) /Sense of Self/Negative/Rejected  
 72 (6 2 5) /Sense of Self/Negative/Unworthy  
 73 (6 2 6) /Sense of Self/Negative/Rootless  
 74 (6 2 7) /Sense of Self/Negative/Vigilant  
 75 (6 2 8) /Sense of Self/Negative/Fragile  
 76 (6 2 9) /Sense of Self/Negative/Insubstantial  
 77 (6 2 10) /Sense of Self/Negative/Hating  
 78 (6 2 11) /Sense of Self/Negative/Not good enough  
 79 (7) /Personal Characteristics  
 80 (7 1) /Personal Characteristics/Resilience  
 81 (7 2) /Personal Characteristics/Feisty  
 82 (7 3) /Personal Characteristics/Sensitive  
 83 (7 4) /Personal Characteristics/Controlling  
 84 (7 5) /Personal Characteristics/Vigilant  
 85 (8) /Health Issues  
 86 (8 1) /Health Issues/Physical  
 87 (8 1 1) /Health Issues/Physical/Disability  
 88 (8 1 2) /Health Issues/Physical/Serious illness  
 89 (8 1 3) /Health Issues/Physical/Chronic illness  
 90 (8 2) /Health Issues/Mental  
 91 (8 2 1) /Health Issues/Mental/Depression  
 92 (8 2 1 1) /Health Issues/Mental/Depression/Post-natal  
 93 (8 2 1 2) /Health Issues/Mental/Depression/Reactive  
 94 (8 2 1 3) /Health Issues/Mental/Depression/Endogenous  
 Description:

I will use this code when people are talking about their depression as on-going.

```

95      (8 2 2) /Health Issues/Mental/Psychosis
96      (8 2 3) /Health Issues/Mental/Bi-Polar
97      (8 2 4) /Health Issues/Mental/Eating disorder
98      (8 2 5) /Health Issues/Mental/Addiction
99      (8 2 5 1) /Health Issues/Mental/Addiction/Alcohol
100     (8 2 5 2) /Health Issues/Mental/Addiction/Drugs
101     (8 2 5 3) /Health Issues/Mental/Addiction/Gambling
102     (8 2 5 4) /Health Issues/Mental/Addiction/Sex
103     (8 2 6) /Health Issues/Mental/Non-specific
104     (8 2 7) /Health Issues/Mental/Breakdown
105     (8 2 8) /Health Issues/Mental/Anxiety
106     (9) /Environment
107     (9 1) /Environment/Place
108     (9 1 1) /Environment/Place/Stable
109     (9 1 2) /Environment/Place/Changing
110     (9 2) /Environment/Economic
111     (9 2 1) /Environment/Economic/Poverty
112     (9 2 2) /Environment/Economic/Comfort
113     (9 2 3) /Environment/Economic/Wealth
114     (9 3) /Environment/Social
115     (9 3 1) /Environment/Social/Silencing
116     (9 3 2) /Environment/Social/Accepting
117     (9 3 3) /Environment/Social/Frightening
118     (9 3 4) /Environment/Social/Terrifying
119     (9 3 5) /Environment/Social/Cold
120     (10) /Strategies
121     (10 1) /Strategies/Physical
122     (10 1 1) /Strategies/Physical/Gym
123     (10 1 2) /Strategies/Physical/Walk
124     (10 1 3) /Strategies/Physical/Bush walk
125     (10 1 4) /Strategies/Physical/Chocolate
126     (10 1 5) /Strategies/Physical/Cigarettes
127     (10 1 6) /Strategies/Physical/Sex
128     (10 2) /Strategies/Cultural
129     (10 2 1) /Strategies/Cultural/Cultural
130     (10 2 2) /Strategies/Cultural/Reading
131     (10 2 3) /Strategies/Cultural/Craft
132     (10 2 4) /Strategies/Cultural/Art
133     (10 3) /Strategies/Interpersonal
134     (10 3 1) /Strategies/Interpersonal/Friends
135     (10 3 2) /Strategies/Interpersonal/Womens Groups
136     (10 3 2 1) /Strategies/Interpersonal/Womens
Groups/Lesbian
137     (10 3 2 2) /Strategies/Interpersonal/Womens
Groups/Witches
138     (10 3 2 3) /Strategies/Interpersonal/Womens Groups/Child
focussed
139     (10 3 2 4) /Strategies/Interpersonal/Womens
Groups/Charitable
140     (10 3 2 5) /Strategies/Interpersonal/Womens
Groups/Political
141     (10 3 2 6) /Strategies/Interpersonal/Womens Groups/Other
142     (10 3 3) /Strategies/Interpersonal/Spiritual groups
143     (10 3 4) /Strategies/Interpersonal/Whanau
144     (10 3 5) /Strategies/Interpersonal/Therapy
145     (11) /Events Descriptive
146     (11 1) /Events Descriptive/Rearing pre-school children
147     (11 2) /Events Descriptive/Curling up in foetal position

```

148 (11 3) /Events Descriptive/Hugging trees  
 149 (11 4) /Events Descriptive/Staying in bed  
 150 (11 5) /Events Descriptive/Unable to dress  
 151 (11 6) /Events Descriptive/Doing everything slowly  
 152 (11 7) /Events Descriptive/Being normal  
 153 (12) /Role

Description:

This applies to the role of the Heroine of the story. The role she takes on at different stages of the narrative.

154 (12 1) /Role/Peacemaker

Description:

This applies to the role of the Heroine of the story. The role she takes on at different stages of the narrative.

155 (12 2) /Role/Caregiver  
 156 (12 3) /Role/Advocate  
 157 (12 4) /Role/Slave  
 158 (13) /Affect  
 159 (13 1) /Affect/Flat  
 160 (13 2) /Affect/Absent  
 161 (13 3) /Affect/Hate  
 162 (13 4) /Affect/Terror  
 163 (13 5) /Affect/Anomie

Description:

Lack of the usual social or ethical standards - but this is the word Anne used in Paragraph 111.

164 (14) /descriptive  
 165 (14 1) /descriptive/descriptive  
 166 (14 1 1) /descriptive/descriptive/disconnected  
 167 (14 1 2) /descriptive/descriptive/disorganised  
 168 (14 2) /descriptive/dislocation

Description:

My first new coding - these are experiences such as the end of a marriage, or the sense of having no culture, or the discovery that sex is no good, or the breakdown of parents marriage which create a major break in the heroine's dominant meaning making story.

169 (15) /Meaning making

Description:

Interests, or belief systems that are seen by the woman as providing meaning - a way of making sense of their life.

170 (15 1) /Meaning making/Astrology

Description:

Interests, or belief systems that are seen by the woman as providing meaning - a way of making sense of their life.

171 (15 2) /Meaning making/Spiritualism  
 172 (15 3) /Meaning making/Organised religion  
 173 (16) /Tree Node  
 174 (18) /Disrupted Life

Description:

the tree node for coding the depression report.

175 (18 1) /Disrupted Life/behaviour  
 176 (18 2) /Disrupted Life/emotions  
 177 (18 3) /Disrupted Life/reactions of others  
 178 (18 3 1) /Disrupted Life/reactions of others/naming

179 (18 3 2) /Disrupted Life/reactions of others/involve mh  
profs

180 (18 4) /Disrupted Life/relationships

181 (18 5) /Disrupted Life/self care

182 (18 6) /Disrupted Life/embodied d

183 (18 7) /Disrupted Life/self concept

184 (18 8) /Disrupted Life/Suicidal thoughts~attempts

185 (18 9) /Disrupted Life/images~metaphors~descriptions

186 (18 10) /Disrupted Life/theory of d

187 (18 11) /Disrupted Life/duration

188 (18 12) /Disrupted Life/masking

189 (18 13) /Disrupted Life/Isolation

Description:

This also includes a sense of otherness, being different.

190 (18 14) /Disrupted Life/Thinking

191 (18 15) /Disrupted Life/Meaninglessness~hopelessness

Description:

This also includes a sense of spiritual loss or nothingness. Like Jane's God being pushed to the periphery.

192 (18 16) /Disrupted Life/variableness

193 (18 17) /Disrupted Life/beginnings analysis

Description:

the final (I hope) analysis of the preonset data. Hopefully only 5-6 nodes under here, and they will be analysed using the document I have already written.

194 (18 17 1) /Disrupted Life/beginnings analysis/Always  
already depressed

Description:

The woman has a theory that depression has always been a part of her life, either for biological, genetic, hereditary or family or cultural reasons. This is not the old endogenous, it may be because of ethnicity

195 (18 17 2) /Disrupted Life/beginnings analysis/Broken  
dreams

Description:

The woman implies a theory of depression which includes broken dreams, the end of marriage, the failure of career (Marge) etc

196 (18 17 3) /Disrupted Life/beginnings  
analysis/Dislocation~isolation

Description:

the woman has a theory of depression which includes being isolated, unsupported, distant from family and birth place or country of origin

197 (18 17 4) /Disrupted Life/beginnings analysis/Low self  
worth

Description:

The woman has a low sense of self which precedes her depression

198 (18 17 5) /Disrupted Life/beginnings analysis/Bad things  
happened

Description:

This could be trauma, but does not include the broken dreams stuff

199 (18 17 6) /Disrupted Life/beginnings analysis/Physical  
health problems

Description:

The beginning story focuses on physical health or disability issues

200 (18 17 7) /Disrupted Life/beginnings analysis/Tree Node  
201 (19) /Functioning though disrupted  
202 (20) /fg speakers  
203 (21) /Search Results  
204 (21 1) /Search Results/Single Text Lookup

Description:

Text Search: text matching the pattern ' women'

Scope: { Agency, alcohol and recreational drugs, alienated from home, Animals, pets, Anne~3~, Anne~3~ - Memo 2, Awareness to keep D under control, beginnings of depression Jan04, Charlotte~12~, Chloe~6~, 'chocolate solutions', Christine~15~, Colour in life, depressionApr04, Elizabeth~9~, Endogenous~reactive depression, Fiona~16~, Fiona~16~ - Memo, getting into your soul, Hannah~5~, Have to be happy, History of mental illness;, Isobel, Isolation, Jane~10~, Journal, Karen~17~, Kate~13~, Katy two episodes, Katy~19~, Kay~8~, Linda~4~, Marge~7~, Masked depression, Meaning-making pre Onset, medication, Minaora~1~, More than chocolate, Naomi~18~, nobody recognised the early signs, Participant Stories, Pre-onset report all p's 27~10~02, professional discourses, psycho-somatic symptoms~ early onset, Psychosynthesis, Ruth~11~, Secrets, story telling, the bush is a sanctuary, Women's groups }

Result is a node coding all the finds: (21 1) /Search Results/Single Text Lookup (n)

Document finds are spread to (no spread). Node finds are spread to (no spread).

205 (21 2) /Search Results/Single Text Lookup 2

Description:

Text Search: text matching the pattern ' women'

Scope: { Agency, alcohol and recreational drugs, alienated from home, Animals, pets, Anne~3~, Anne~3~ - Memo 2, Awareness to keep D under control, beginnings of depression Jan04, Charlotte~12~, Chloe~6~, 'chocolate solutions', Christine~15~, Colour in life, depressionApr04, Elizabeth~9~, Endogenous~reactive depression, Fiona~16~, Fiona~16~ - Memo, getting into your soul, Hannah~5~, Have to be happy, History of mental illness;, Isobel, Isolation, Jane~10~, Journal, Karen~17~, Kate~13~, Katy two episodes, Katy~19~, Kay~8~, Linda~4~, Marge~7~, Masked depression, Meaning-making pre Onset, medication, Minaora~1~, More than chocolate, Naomi~18~, nobody recognised the early signs, Participant Stories, Pre-onset report all p's 27~10~02, professional discourses, psycho-somatic symptoms~ early onset, Psychosynthesis, Ruth~11~, Secrets, story telling, the bush is a sanctuary, Women's groups }

Result is a node coding all the finds: (21 1) /Search Results/Single Text Lookup (n)

Document finds are spread to enclosing paragraphs. Node finds are spread to enclosing paragraphs.

206 (22) /Gym  
207 (23) /Seeking Solutions  
208 (23 1) /Seeking Solutions/ignore it  
209 (23 2) /Seeking Solutions/try oneself  
210 (23 3) /Seeking Solutions/GP



211 (23 4) /Seeking Solutions/medication  
 212 (23 5) /Seeking Solutions/therapy  
 213 (23 5 1) /Seeking Solutions/therapy/individual therapy  
 214 (23 5 1 6) /Seeking Solutions/therapy/individual  
 therapy/hospital  
 215 (23 5 2) /Seeking Solutions/therapy/group couple therapy  
 Description:  
 includes couple counselling  
  
 216 (23 6) /Seeking Solutions/hospital visit or stay  
 217 (23 7) /Seeking Solutions/agency  
 218 (23 8) /Seeking Solutions/self-help awareness  
 219 (23 9) /Seeking Solutions/psychoeduc  
 Description:  
 includes reading self-help books or informative books such as Jack's  
 silencing the self  
  
 220 (23 10) /Seeking Solutions/friends  
 221 (23 12) /Seeking Solutions/doing socially  
 222 (23 12 11) /Seeking Solutions/doing  
 socially/transpersonal  
 223 (23 13) /Seeking Solutions/physical~geographical doing  
 Description:  
 this includes choosing to leave someone, or to move to a new place or  
 job  
  
 224 (23 14) /Seeking Solutions/support people  
 Description:  
 this includes mentors, and anyone who is not family who is  
 significant in the change process Also includes animals  
  
 225 (23 15) /Seeking Solutions/family  
 226 (23 16) /Seeking Solutions/alternative treatment  
 Description:  
 this may be st johns worst or massage or naturopath or hypnosis etc.  
  
 227 (23 17) /Seeking Solutions/distraction  
 228 (23 18) /Seeking Solutions/meaning making  
 Description:  
 anything which is talked of as making meaning of life, activity,  
 belief systems, structures such as astrology  
  
 229 (23 19) /Seeking Solutions/time out  
 230 (24) /OK Life  
 231 .focus group participants  
 232 .Has children~  
 233 .Has children~:No children  
 234 .Has children~:Yes children

## ***APPENDIX P***

### **Example of a Mind Map for a Disrupted Life**

Jolly Good Reasons

5/5/04.  
Seeds of Resilience

## A Disrupted Life

Reactions of others

Naming

involving mhr  
professing

What about it  
it was successful!!

Behaviour

Slowed down shaggy.  
Facial position shift  
Angry  
Hyperactive

Emotions

Relationships

Self-care

Isolation

Thinking

Meaninglessness/  
Hopelessness.

Suicidal  
thoughts/attacks.

Images/Metaphors  
description

Embodied D

Self-concept

Theory of D

Dwelling

Masking

Functioning, though disrupted.

Holding on  
Mothering...

~~What was it~~ How do they talk about it?

A life no longer Disrupted

Alternative strategies

Turning point shift -

## ***APPENDIX Q***

### **Mind Map: Out of the Chaos of a Life Seriously Disrupted by Depression**



30 Oct 2005

play centre  
rape on sis  
women motorcyclists  
motor-cycling  
walking - in the bush  
ocean swimming  
belly dancing

women are able to  
journey towards a meaningful life.

finding  
Meaningful work  
becoming a therapist  
educator  
tour guide  
support for speed readers  
kid

music  
cross-stitch

reducing stress  
learning back'ship  
changing work.

pets

Drawing on  
resilience factors

Through symptom relief created by  
chocolate, 'counselling', anti-depressant by  
medications, CBT

From a landscape of 'safety',  
~~created~~ built through relationships,  
friendships, physical well-being  
mentors -

OUT OF THE CHAOS OF A  
LIFE SERIOUSLY DISRUPTED BY DEPRESSION

## ***APPENDIX R***

### **Ethics Approval from The University of Waikato**



Faculty of Arts and Social Sciences  
Te Kura Kete Aronui  
The University of Waikato  
Private Bag 3105  
Hamilton, New Zealand

Telephone 64-7-838 4080  
Facsimile 64-7-838 4636  
Email wfass@waikato.ac.nz



The  
University  
of Waikato  
Te Whare Wānanga  
o Waikato

6 March 2000

Jan Wilson  
51 Stanley Avenue  
Milford  
Auckland 1309

Dear Jan,

Thank you for your well presented proposal.

The Human Research Ethics Committee recommend that the following changes are made, but do not require you to resubmit your proposal.

On p.4 mention is made of 'personal networking' – the committee is concerned that friends may be used.

Please add the clause that a) if participants do not wish to answer any question they are not obliged to give a reason, b) participants can withdraw at any time and are not obliged to give a reason.

As Hilary Lapsley is leaving the university at the end of June 2000, a new Chief Supervisor will need to be appointed.

Kind regards.

Yours sincerely,

Anne Green  
Chair  
Human Research Ethics Committee

## ***APPENDIX S***

### **Ethical Approval from Auckland University of Technology**



# MEMORANDUM



## Academic Registry – Academic Services

---

To: Jan Wilson  
From: Madeline Banda, Executive Secretary, Ethics Committee  
Date: 5 June 2000  
Subject: Application 00/10 Women and Depression: Women's ways of coping with the experience of depression

---

Dear Jan

At the meeting of AUTEK on 29 May your response to a request for clarification on several areas of concern was discussed.

The Committee was appreciative of the depth of your response and the concern and interest shown for your subjects.

I am pleased to inform you that your application is approved for a period of two years until 29 May 2002.

You are required to submit the following to AUTEK:

- A brief annual progress report indicating compliance with the ethical approval given.
- A brief statement on the status of the project at the end of the period of approval or on completion of the project, whichever comes sooner.
- A request for renewal of approval if the project has not been completed by the end of the period of approval.

The Committee wishes you well with your research.

Please include the reference number and study title in all correspondence and telephone queries.

Yours sincerely

A handwritten signature in blue ink, appearing to be 'MB', is written over the typed name.

Madeline Banda  
Executive Secretary  
AUTEK

Handwritten initials 'PB' in blue ink, located to the left of the typed name.

## ***APPENDIX T***

### **DSM Diagnostic Criteria for Major Depressive Disorder**

# DSM IV

## Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

**Note:** Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

(1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful).

**Note:** In children and adolescents, can be irritable mood.

(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)

(3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.

**Note:** In children, consider failure to make expected weight gains.

(4) insomnia or hypersomnia nearly every day

(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

(6) fatigue or loss of energy nearly every day

(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. The symptoms do not meet criteria for a Mixed Episode.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

# Major Depressive Disorder

## Single Episode

A. Presence of a single Major Depressive Episode

B. The Major Depressive Episode is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

C. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode.

**Note:** This exclusion does not apply if all the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition.

## Recurrent

A. Presence of two or more Major Depressive Episodes.

**Note:** To be considered separate episodes, there must be an interval of at least 2 consecutive months in which criteria are not met for a Major Depressive Episode.

B. The Major Depressive Episodes are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

C. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode.

**Note:** This exclusion does not apply if all the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects or a general medical condition.

*Specify* (for current or most recent episode):

**Severity/Psychotic/Remission Specifiers**

**Chronic**

**With Catatonic Features**

**With Atypical Features**

**With Postpartum Onset**

*Specify*

**Longitudinal Course Specifiers (With and Without Interepisode Recovery)**

**With Seasonal Pattern**