TAKING OFF THE ROSE COLORED GLASSES:
EXPLORING WOMEN'S EXPERIENCES WITH DEPRESSION

BY

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ABSTRACT

This study explores the experiences of women, between the ages of twenty-five and forty-four, who describe themselves as being depressed. Research, to this point, has largely concentrated on investigating the possible causes and predictors of depression in women, using quantitative methodology. The purpose of this research is to create a new discourse by conducting qualitative research utilizing feminist principles. This approach gives voice to women and validates their experiences. Unstructured interviews, which elicited rich information, were conducted with six women who volunteered for this study. Their stories were audio taped and then analyzed utilizing the constant comparative method. Three themes emerged from the analysis: 1) Losing the Self, 2) Searching for Meaning and 3) Regaining the Self. Losing the Self captures the essence of the women's experiences as they talked about the physical and emotional changes they went through, and the feelings these changes gave rise to. Searching for Meaning describes the importance the women attached to making sense of their experiences, and was both internal and external as they looked at issues around control and understanding, and trying to find out who they were. Regaining the Self describes the women's healing journey as they discuss what they needed, whom they needed it from and how, and the importance of education around depression and women's issues. The results indicate that while there are commonalities, each woman's experience with and understanding of depression is unique, which stresses the importance of all women being able to give voice to their own experiences and to have them validated.
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CHAPTER ONE

Introduction

About three years ago, I was diagnosed with a major depressive episode. At that time I had been working, for about seven years, counselling suicidal and depressed youth and their families, and providing grief and loss counselling. Even though I had been working intimately with depression, counselling many depressed females, I did not realize I was depressed. There had been many changes in my place of employment, and I thought I was just experiencing stress and burn-out. I had a hard time getting out of bed in the morning, even though I was not sleeping much. I dreaded going in to work, and found it difficult to keep track of what I needed to do. My paper work was falling behind, and I only attended meetings if I absolutely had to. I was frequently in tears, and this was very difficult for me as I was raised in a family where crying was considered a sign of weakness and was only acceptable if I was in extreme physical pain or alone in a room. I even found myself crying in the car between appointments, for no apparent reason.

At home, I found myself unable to deal with daily household chores, withdrawing into myself, and ignoring or snapping at my family and friends. I kept thinking that I needed to pull myself together. I couldn't understand what was wrong with me. I had always prided myself on being on top of things, and felt I should be able to handle things. I decided I would join a gym as perhaps I needed more physical exercise. I was also doing what I thought I should to take care of myself: I would go for walks, sit in the hot tub,
listen to music, and try to read. I found that reading was impossible as I could not concentrate long enough to remember the words I had just read, and could not even follow a half hour show on television. I gave up cooking, and only ate if someone put food in front of me. I felt out of control and that I was losing my mind.

I finally decided I had to take some time off work. To do this, I had to see my doctor so I could take it as medical leave. I think that had I not been "forced" to see my doctor, I would not have gone and it would have taken a lot longer for me to have sought help. I was shocked to find myself diagnosed with depression. Having the background from my work made it easier to deal with as I knew what to expect and what I needed to do to help myself. However, the first antidepressant medication made me feel like I was losing my mind. I remember thinking that I was going crazy and would wake up one day, years from then, in a hospital and I would have missed my children growing up and my life. I returned to the doctor and had my medication changed, which helped immensely.

While I was going through this process, I spent most of my time in front of the computer mindlessly playing games. I found that I could spend eight hours doing this and be totally shut down, letting myself not think. For months, I did not even go and use the bank machine, never mind going into the bank, as it was just too difficult. I did, however, force myself to keep in touch with a couple of close friends because I knew that if I did not make this effort it would be really easy for me to just shut myself away for ever. My family was incredible supportive during this time and just let me be however I needed to be. It was very hard on them though because they never knew if I was going to be crying,
acting like my typical self, or angry. Even after I was no longer depressed, the effects remained with me. For months, I was never sure if I was responding appropriately to a situation. I had to constantly check my perceptions with other people because I still doubted my ability to trust my emotions. Still today, I find myself checking out my perceptions with others as I constantly feel the need to monitor my emotional state.

Around the same time I became depressed, my youngest sister was also diagnosed with depression. This was very difficult for her as she felt she was at fault and that there was something wrong with her. She did not want anyone to know, thereby avoiding the stigma, but this also limited the support and understanding she received. Shortly before my diagnosis, two of the women I worked with and three close friends were all diagnosed with depression. It seemed to me that an epidemic was going on and I started to wonder what was happening to women that so many of us were depressed. As I started talking to women about my experiences, more and more women started telling me about their depression.

All of these women were in their mid-twenties to mid-forties. Some of the women were married with and without children, some were single parents, some were single, some were heterosexual, some lesbian, and some bi-sexual. Most of the women worked outside the home as well as being the primary caretaker at home. Their socioeconomic status varied, with single moms on Income Assistance, the working poor, to middle and upper income. These women lived all across Canada and came from a variety of ethnic backgrounds. The only commonality seemed to be that we were all women. This led me to
look at what, in particular, there is about women's lives that makes us vulnerable to depression and how the experience of being depressed effects women.

As I started reading more of the literature I found a wealth of information on the signs and symptoms of depression, the causes of depression, and the treatment of depression, but very little on women's actual experiences with depression. The most common signs and symptoms of depression are a persistent sad, anxious, or "empty" mood, feelings of hopelessness and pessimism; feelings of guilt, worthlessness, and helplessness; loss of interest or pleasure in activities which were once enjoyed, including sex; insomnia, waking early, or oversleeping; appetite changes and weight loss or weight gain; decreased energy and fatigue; restlessness and irritability; difficulty concentrating, remembering, and making decisions; persistent physical symptoms such as headaches and chronic pain that do not respond to treatment, and thoughts of death or suicide, and suicide attempts (Green & Dorwick, 1995; Goldberg, 1995).

According to the literature, about 15 percent of the general population will suffer from depression at some time in their lives (Canadian Mental Health Association, 1987). The American Psychiatric Association (1997) estimates that one in four women are depressed but that only one in five will seek treatment. Women are at higher risk for most types of depression (McGrath, Keita, Strickland & Russo, 1990; Green & Dorwick, 1995; Goldberg, 1995) and a recent major epidemiological study in the United States found that 80 percent of women would experience depression at some point in their lives (Downey, 1996). Women are twice as likely to be depressed as men (Narine & Smith, 1984) and a
recent National Comorbidity Survey of more than 8000 people aged 15-54 found that 21 percent of women compared to 13 percent of men were depressed.

The following chart (figure 1) shows the comparison rates of depression between women and men, and indicates that worldwide, women experience higher rates of depression (Medscape, 1998).

**Figure 1 - Lifetime Rate of Depression**

Women today suffer from depression at rates ten times higher than their grandmothers (Spaulding, 1995), and women between the ages of 25 and 44 are particularly at risk (Jack, 1987; Weissman, Myers & Thompson, 1981). Therefore, the question this research addresses is "How do women, between the ages of twenty-five and
forty-four, describe their experiences with depression?"

This research is qualitative in design, utilizing feminist methodology. Feminist methodology has grown out of an important qualitative leap from the feminist critique of the social sciences where women have been invisible as objects of study and their experiences and reality have been discounted or minimalized (Gottfried, 1996). Thus, this research will be going beyond most current research, which is quantitative, and gives voice to women's experiences that have previously been silenced. The purpose of this study is for social workers and other helping professionals to gain a deeper understanding of women's experiences with depression, thereby promoting appropriate services.

Most clients who seek the help of social workers are female. For social workers to assist women in making positive changes in their lives, social workers need to understand the reality of women's experiences. It has been well documented that many women suffer from depression that affects the way they eat and sleep, the way they feel about themselves and the way they talk about things. These thoughts and feelings may be experienced as feeling sad, but can also be experienced as a numb or empty feeling, or no awareness of feeling at all. Depressed people may experience a loss of ability to feel pleasure about anything and cannot just “pull themselves together.” Many people, however, view depression as a character defect or lack of will power, thereby stigmatizing those suffering from depression as having an inherent personal weakness or fault (Canadian Mental Health Association, 1987; Green & Dorwick, 1995; National Institute of Mental Health, 1997).
Many factors appear to contribute to depression in both women and men, but varied factors unique to women's lives are suspected of contributing to their depression. Developmental roles, reproduction, hormones, abuse and oppression, and interpersonal relationships are considered to play a part in women's depression. Stress is also known to affect depression but each individual is unique, with many different causative factors combining in varying amounts and in a constant state of flux, influencing and interacting on each other (Schwartz & Schwartz, 1993).

The causes of depression have been attributed to biology, where genes transfer a vulnerability for depression making depression hereditary, or to physiological disturbances in the neurochemical, endocrine and limbic systems; to psychology, where, for example, the person's development is looked at within the family of origin; or to social influences such as society and culture (Schwartz & Schwartz, 1993). Historically, the European psychiatrist, Emil Kraepelin, viewed depression as a disease, with an etiology and an outcome, and first categorized it through defining it as a mental disorder. He determined that the causes were primarily found in biology, particularly genetics, and physiology, and that first there was a biological or biochemical disorder, followed by psychological developments. Since depression was seen, through this model, as a disease, the main treatments were somatic (Schwartz & Schwartz, 1993). Originally, patients diagnosed with severe depression were treated in mental institutions, where doctors determined that, while there may have been a biological basis, depressed people had defective constitutions and were responsible for their own depression (Parker & Hadzi-Pavlovic, 1996).
In contrast, the American psychiatrist, Adolph Meyer, developed the continuity hypothesis of depression, viewing it as a psychological problem and not as a disease. The continuity hypothesis of depression sees depression along a continuum, with normal ranges of feelings at the left. As the line toward depression progresses, the blues increase and interfere with function leading to neurotic depression, with an increased lack of functioning, to the point of delusions, hallucinations, suicides, and psychotic depression at the far right. This view of depression is seen as primarily a psychological reaction, with a psychological problem first followed by physiological effects. As depression was seen, through this model, as a psychological problem, the main treatment was psychotherapy (Schwartz & Schwartz, 1993).

Looking at the alarming rates of depression in women led me to reading literature on women's lives. Hook (1996) states that role overload, conflict, troubled relationships, and trauma may contribute to women's depression. Many women are faced daily with stressful events, violence, and loss, leading to feelings of self-doubt, blame, guilt, worthlessness, impotency, fear, and depression, which may be reinforced by police, hospitals, and other social institutions. The continual threat of violence deprives some women of choices and control over life situations, and women of color face additional prejudices, leaving them with even less choice and control. Women are taught that being indecisive is acceptable behavior for them and that their role is one of peacemaker. Faced with many daily conflicts that lack resolution, have only temporary solutions, and constantly require renegotiating, women live with long standing, unresolved conflicts that
may contribute to depression (Narine & Smith, 1984).

Researchers have consistently found that women who are abused are depressed or report higher rates of depressive symptoms (Agulier & Nightingale, 1994; Canadian Mental Health Association, 1987; Cascardi, O'Leary, Lawrence, & Schlee, 1995) and suggest that the level of depression increases with the severity of the violence (Cascardi et al., 1995; Gelles & Straus, 1988). The American Psychiatric Association (1997) estimates that 37 percent of women have been sexually or physically abused by the age of 21, and that the actual number may be closer to 50 percent. Women who have been the victims of rape or incest show increased levels of depression, fear, mistrust, and guilt leading to marital and relationship problems, sexual difficulties, and self-directed negative attributions (Able, Becker, Skinner, & Treacy, 1982; Bernstein, Miller, & Williams, 1982; Carlson & Quinca, 1989; Orbuch, Harvey, Davis, & Merback, 1994). Women who have experienced abuse have lower levels of self-esteem, feel powerless, have higher rates of depression, and poor coping skills (Able, Becker, Skinner, & Treacy, 1982; Bernstein, Miller, & Williams, 1982; Carlson & Quinca, 1989; Orbuch, Harvey, Davis, & Merback, 1994).

When women are depressed they worry more, have an increased negative self-image, and this results in a vicious spiral of self-hate. When women are worried, they often preface their comments with “I know this is silly but,” indicating that they do not take themselves seriously, which in turn leads to an increase in depression. Their feelings are expressed in what are described as “weak” ways, for example they may cry when they
are angry, which in turn leads to labelling women as hysterical, overly emotional, or attention seeking. They are told that real women are supposed to express their feelings, yet, when they do, they are put down or ignored (Narine & Smith, 1984).

Still today, if a woman is from a minority group, lesbian, First Nations, disabled, aged, or poor, she suffers additional prejudice. Women who are poor experience discrimination at all levels. They have no access to credit, some health services (such as chiropractors and physiotherapists who require a small fee for service), transportation, and education (Adams, 1975). While they may receive the very minimum basics to survive, their diets are often poor and they cannot afford better food or dietary supplements. They can rarely afford to go out socially, and, when they do, they may be stigmatized and told they should not spend money on entertainment. Women who go without social interaction with peers and occasional entertainment may become depressed and unable to function at home, yet this is often society’s expectations of poor women (Abowitz, 1986).

The group at highest risk for poverty are single parent families, which are usually headed by women. A lack of affordable, decent housing affects the physical and psychological health of people (Gunderson, Mudzynski & Keck, 1990). When the majority of a mother’s income is spent on shelter that is inadequate to meet her needs or the needs of her family, she may become physically and emotionally sick from the struggle of trying to maintain a decent home.

First Nations’ women are still working to overcome the horrendous effects of the
residential schools. They were taken from their communities, were not allowed to speak their own languages, and experienced physical, sexual, and emotional abuse. Traditional family life was eroded and whole generations of children were deprived of their culture and, just as importantly, their parental role models. Due to this deprivation, mothers have few parenting skills. They did not have role models for traditional parenting, and, as marginalized women, frequently living in poverty, have no supports for raising their children. These women and other minority women may experience depression as they are caught between two cultures with differing messages and expectations. Likewise, lesbian women may experience depression as they daily experience discrimination and prejudice, and may be the victims of violence. Disabled women may be part of any of the above groups and, in addition, are faced with daily barriers that may prevent them from leading the lives they would choose, which can also result in depression.

There are obviously a variety of factors that could come into play in explaining the reasons for women's depression and perhaps it is a combination of these factors, varying from woman to woman, that is the cause of depression. Whatever the cause, however, what I found lacking in the literature was information on women's lived experiences with depression and their understanding of their lives. This could be due to the fact that most research on depression has been quantitative and from a male perspective. This thesis addresses the topic of women's experiences with depression in hopes of deepening our understanding of women and depression and suggesting new areas for research on the subject. Therefore, this thesis encompasses a number of components. The next chapter
examines the literature on depression and the literature on the importance of studying women's lives. Chapter three discusses the methodology used for this study, chapter four analyzes the results of the research, and chapter five concludes with implications for social workers and other helping professions.
CHAPTER TWO

Literature Review

Women's depression has been attributed to biological, behavioral, and sociological causes. Biological reasons such as menstruation, pregnancy and childbirth, and menopause cause hormonal changes which can contribute to depression; passive behaviors and avoidance create pessimistic, negative cognitive thinking styles and contribute to negative self-images; socialization roles, poverty, and abuse have all been indicated as contributing to depression (Canadian Mental Health Association, 1987; Green & Dorwick, 1995; McGrath et al., 1990; Mental Health Association of Colorado, 1995; Ruble, 1995). In epidemiological studies of depression, factors that have been found to increase a woman's vulnerability to depression are having three or more children under the age of fourteen living at home, a lack of an intimate, confiding relationship, the death of a mother before age eleven, marriage, and a lack of paid employment outside the home (Corob, 1987; Jack, 1991; Narine & Smith, 1984; Spaulding, 1995). Violence and abuse have also been found to be causal effects of women's depression (Canadian Mental Health Association, 1987; Green & Dorwick, 1995; Hook, 1996; Mental Health Association of Colorado, 1995; McGrath et al., 1990).

Women's depression has also been attributed to a variety of social factors. Jack (1987) states that women's risk for depression is associated with a woman's socioeconomic status and varies with the role she occupies. Ruble (1995) states that because girls are more closely watched and protected, they are less likely to become
independent and that this low self-efficacy may lead to feelings of pessimism and hopelessness. These pessimistic, negative cognitive thinking styles contribute to negative self-images (Canadian Mental Health Association, 1987; Keifer, 1990; McGrath et al., 1990; Ruble, 1995) that in turn lead to depression.

Bandura's social learning theory emphasizes the importance of observing and modelling the behaviors, attitudes, and emotional reactions of others. It explains human behavior in terms of continuous reciprocal interaction between cognitive, behavioral, and environmental influences. Women's feelings are entwined with the patriarchal culture we live in and, according to Carmen et al. (1981), gender roles and women's subordinate and devalued status are major contributing factors for depression in women.

The next three sections explore socio-political feminist, biological, and behavioral theories of depression in order to understand the different explanations that have been given for women's depression. The research suggests that because women are more vulnerable to depression than men, in all contexts, certain characteristics attached to being female create feelings of helplessness, low self-esteem, self-alienation, and hopelessness in women.

**Socio-Political Feminist Theories of Depression**

This section explores the literature on how women have been viewed and talked about as a way to explore a feminist analysis of women's experiences with depression. Meanings are culturally and socially determined, and experiences with depression may have different meanings dependent upon gender, ethnicity, class, sexual orientation, and disability. Feminist analysis examines power and inequalities and provides a framework for
understanding women's experiences.

It has only been in the last seventy years that women were accorded the same rights and liberties as men. It was not until the “Persons Case” in 1929 that women became persons in Canada where they could participate in public life and be appointed to the senate. Emancipation for women occurred in the late 1920s and 1930s, depending on which province women lived in, but First Nations' women and other minority women were not allowed to vote until much later. Women’s voices have generally been left out of history and research and their experiences and realities marginalized. According to Grant (1993), objectivity is really the misnomer given to the world when it is viewed and experienced from the male perspective. The knowledge that society has viewed as “truth” is really male opinion (Grant, 1993).

Obviously, there are still prevailing gender constructs that may limit, constrain and/or shape what we can do as women. Feminist theory is the articulation and questioning of the rules and regulations that govern gender. The ways in which we speak about sex and gender become part of our lives and alter those lives. By asking about the cultural dimension of gender differences, feminism examines the taken for granted masculine and feminine roles and the ways they are internalized by asking where sexism is lodged and how it can be dislodged, feminism politicizes gender (Forganis, 1994).

Feminist theory recognizes the central role gender plays in people’s lives. This includes the ways women are thought about, talked about, written about, and ignored. It looks at women’s roles in the workplace, ways of bearing and rearing children, and patterns of interpersonal public and private behavior. It is a paradigm challenge to
androcentric theory. It challenges conventional viewpoints relying on masculine categories that exclude women’s perspectives, and are distorted and biased in ways that account for social reality. Feminist theory brings previously hidden objects into public view, and, in the process, rewrites the way we look at people. At it’s best, it is a transmittal between self and power. It allows for questions of how a woman comes to think of herself, how a self is fashioned, how she comes to know power, and has the ability to change or resist social constraints. As a social theory, it helps women discover who they are, and to refuse to be what they have been socialized to be (Forganis, 1994).

It is characteristic that when women live in two such simultaneous, different worlds, the public and the private, conflicts arise over underlying preconceptions of who women really are. Women are considered to think contextually and concretely, in more personal and immediate terms with an emphasis on responsibility, while men are considered to think more abstractly with the emphasis on objective, rational rights, obligations, and principles (Forganis, 1994). This leaves many women with the primary responsibility for private life, the home and family, and men with the primary responsibility for public life, business and politics.

Some women’s depression may be, in part, due to their lack of status in society stemming from their primary responsibility for family and home. With the dominant people in society being male, women are labelled as inferior, defective or substandard: for example women are ruled by their emotions and so cannot be expected to make rational choices, and the words men use to describe women are destructive. The dominant males define one or more acceptable roles for women, which are typically to provide services to
males. The functions males prefer are carefully guarded and closed to women. Women are considered not able to perform those functions, and their incapacities are ascribed to innate deficiencies of mind or body, which are immutable or impossible to change, leaving women doubting their own ability (Miller, 1986).

Women are described in, and encouraged to develop, personal psychological characteristics pleasing to men, such as being submissive, passive, docile, dependent, lacking initiative, and unable to act, decide, and think, which are all characteristics of depression. Women are prescribed child like qualities such as being weak, immature and helpless, and are considered well adjusted if they adopt these characteristics. When they show other characteristics such as intelligence, initiative, or assertiveness, there is no room in the dominant framework for acknowledgment, and they are defined as unusual and abnormal. When women constantly live with these messages, they may begin to doubt themselves and become depressed. Men are also the greatest influence in determining philosophy, morality, social theory, and science, legitimizing unequal relations and incorporating them into society’s guiding concepts. Through this, men impede the development of women, and block their freedom of expression and action (Miller, 1986).

In response, women have to concentrate on basic survival so direct honest reaction to such destructive treatment is avoided. Open, self-initiated action must be avoided at all costs, as such actions can actually, in extreme situations, result in death. Women who do not follow the dominant ideology may experience economic hardship, may be socially ostracized, may be psychologically isolated, and may even be diagnosed with personality disorders. In response, women resort to disguised and indirect ways of
acting and reacting. They know others but not themselves, as they internalize the
dominant beliefs. This creates inner tensions between the two opposite worlds, the
internal and external, and could lead to depression (Miller, 1986).

This dichotomy between the two worlds leaves women with fractured identities
and psychic divisions. Women are faced with:

- coming not to know what one knows, the difficulty in hearing or
  listening to one’s voice, the disconnection between mind and body,
  thoughts and feelings, and the use of one’s voice to cover rather
  than convey one’s inner world, so that relationships no longer
  provide channels for exploring the connections between one’s
  inner life and the world of others (Gilligan, 1982, p.xxi).

A marriage that is abusive or not fulfilling, daily housework that is unrecognized
and unrewarded, and child care in isolation or without supports are all areas that can
contribute to depression in women. For some women who have been working prior to
motherhood, when they have children they loose status, pay, social contacts, and may
resent the constant irritation involved with staying home raising children. Being a wife and
mother is a low status job that is unappreciated and taken for granted. Some women may
be financially and emotionally dependent on men, and may be blamed when anything goes
wrong. If they work and leave their children in day care, they may be criticized; yet if they
stay home and find it frustrating, women may be filled with guilt and anger, which they
must swallow and deny as anger is a feared emotion.

If they do not work outside the home, when the children leave, some women are in
danger of feeling empty when they are no longer needed. They may be ashamed to show
others their needs, terrified to show they are weak and vulnerable, as they have always
coped, and feel guilt at not coping, resulting in depression. If they try to return to the
work force, they find that there are few meaningful jobs available, and this may increase their depression. On the other hand, if married women choose not to have children, they are frequently stigmatized, they continually have to justify their choice and are thought of as abnormal and selfish. It is no wonder that some women become depressed in these situations (Narine & Smith, 1984).

If women choose to remain single, they are often stigmatized and face adverse socio-structural conditions. Women earn 33% less than their male counterparts, may have difficulty in acquiring bank loans and mortgages, and are often treated differently in male dominated areas such as car buying and car repair (Abowitz, 1986). In the work force, whether married or single, women may be underpaid, undervalued, and have little opportunity to influence the work process. Women often have to work twice as hard as men to receive promotions, recognition, or status in the work place. In addition, many women who would like to work full-time can only get part-time employment as their work is viewed as a secondary source of income; most of these jobs are in the service sector, and they may be the first to be let go in times of economic cut backs (Corob, 1987; Narine & Smith, 1984). Facing sexual harassment in the work place, many women blame themselves, direct their anger and disgust at themselves, think they should laugh it off, and feel powerless to change the situation. For women who have both a career and family the double role can be exhausting, and as these women may have little time to meet their own needs, they may become more vulnerable to depression (Corob, 1987; Narine & Smith, 1984).

Women are taught at an early age that they should be subordinate and submissive,
that to be good equals self-sacrifice, that they should ignore their self-needs and focus on
giving to others, and that outwardly they should conform and keep their anger inside
(Jack, 1987). This results in an early environment where girls are taught that their "self" is
unacceptable, so they develop a false self to present to the world (Jack, 1987).

The self-in-relation definition which looks at the importance of close relationships
in human development and the negative impact of the lack of secure relationships on
adjustment and development (Jack, 1987 & 1991; Thompson, 1995). This theory states
that people need and seek close connections with others, and when close and secure
connections are not made, attachment behaviors, such as proximity seeking intensify.
Despair and depression result when close relationships are elusive. Self-in-relation theory
sees social intimacy as the central organizer of women’s experiences, and views the
development of depression as tied to the establishment and maintenance of close
relationships (Jack, 1991; Thompson, 1995).

Unfortunately, women’s relationship patterns are seen as deviant because they are
too dependent on relationships, yet developmental, clinical and psychoanalytic
psychologists all agree that women’s orientation to relationships is a central component of
female identity and emotional activity. The relational, connected self differs from the
autonomous self described by western psychologists as that which needs to be attained,
and which is presupposed by most theories of depression. Even though there has been an
increase in biological and epidemiological studies, there has been a lack of basic research
on the psychology of female depression. There has also been a lack of basic research into
external contributors of depression such as violence, socio-economic status, age and
marital status, but a decrease of information on the internal imaginings, feelings and patterns of thought of women (Jack, 1991).

Women are caught in a double bind as society pushes them to define themselves through relationships and then invalidates their connections by derogating the importance of attachments. Women are often depressed over the disruption or conflict in close relationships which is then compounded when they are blamed if the relationship fails or falters. Self-in-relation theory sees that the self is part of a fundamentally social experience, and that attachments provide the foundation for self, mind and behavior. It considers the goal of infant development to become securely attached, not separated, and that connectedness is not a result of a failure of differentiation, but a success of psychic functioning. It considers the attainment of a sense of basic human connectedness to be the goal of development, and that both children and adults have a basic, biosocial need to make secure, intimate connections (Jack, 1991).

Interpersonal intimacy is a profound organizer of female experience and depression results when women are helpless to make and maintain affectional relationships. The ideal is to develop creativity, autonomy, competence, maturity and self-esteem within the context of intimate relationships. Dependency, however, is considered to predispose to or a characteristic of depression, caused by an inordinate attachment to a person, cause or organization, and that self-esteem is derived from external messages. In the literature, depression is now synonymous with exaggerated needs for affection and support. Mental health practices coincide with the dominant values of the culture, which are autonomy, power and wealth, so women’s relational issues are considered of little
importance (Jack, 1991).

The centrality of relationships to women’s sense of self, combined with gender norms for interpersonal behavior, leave women at risk for developing relationship behaviors and beliefs that increase their vulnerability to depression. Women are loved for how well they meet the needs of others, not who they are, and they therefore deny the importance of their own needs. The cost of caring for others without receiving support has been indicated as a cause of depression as women listen to others demands and requirements more than their own feelings and needs. Without mutuality and reciprocity, women feel disconnected, unsupported and alienated from themselves and others. Unfortunately, traditional theories do not account for women’s relational sense of self or the effects of gender norms and inequality between the sexes as factors contributing to depression in women. However, there have also been feminist critiques of self-in-relation theory, as such a focus can be seen to reproduce and maintain the status quo which narrows women’s choices.

Hook (1996) found that how women interact psychosocially contributes to depression. Some women's sense of themselves comes from what others think of them. These women may constantly strive for approval, trying to become who and what they think others want them to be. Denying themselves, relying on others for their self-esteem, or feeling they have failed to be what others want may result in depression. In addition, Hook (1996) states that role overload, conflict, troubled relationships, and trauma may contribute to women's depression. Faced with many conflicts, on a daily basis, that lack resolution, have only temporary solutions, and constantly require renegotiating, women
live with long standing, unresolved conflicts that may contribute to depression (Narine & Smith, 1984).

First Nations' women are still working to overcome the effects of the residential schools where they were taken from their communities, not allowed to speak their own languages, and experienced abuse. They did not have role models for traditional parenting, and, as marginalized women, frequently living in poverty, have no supports for raising their children. These women and other minority women may experience depression as they are caught between cultures with differing messages and expectations. The group at highest risk for poverty are single parent families, which are usually headed by women. Women who are poor experience discrimination at all levels. They have no access to credit, some health services, transportation, and education (Adams, 1975). While they may receive the very minimum basics to survive, their diets are often poor and they cannot afford better food or dietary supplements. A lack of affordable, decent housing affects the physical and psychological health of people (Gunderson et al., 1990). When the majority of a mother's income is spent on shelter that is inadequate to meet her needs or the needs of her family, she may become physical and emotionally sick from the struggle of trying to maintain a decent home. She can rarely afford to go out socially, and they she does, she may be stigmatized and told she should not spend money on entertainment.

Developmental theories state that the predisposition for depression is formed early in life, is a hostile response to a perceived or real loss of a loved object, and results in self-destructive behavior (Klerman & Weissman, 1980). An obsession with love leads to negative self-respect and self-directed hostility, which in turn leads to feelings of
helplessness, worthlessness, emptiness, disillusion, and a poor relationship with others. Barriers between one's own self-concept and images of the external world lead to dependency and a lack of autonomy (Nolen-Hoekema, 1990). However, women's development is explained as identical with male development as all the developmental theories are based on male identity and behavior as the norm with female development viewed as a deviation, so all standards of human development and behavior have been judged according to male standards. With the focus on individuation and individual achievement and maturity equalling personal autonomy, relational concerns are seen as women's weakness rather than human strength. This has left some women questioning the normalacy of their feelings, and altering their judgments in deference to others opinions.

In addition, adult qualities viewed as the capacity to think autonomously, make clear decisions and take responsible action are associated with males and considered undesirable attributes in women (Gilligan, 1982). Some women may find this dichotomy depressing as they strive to assert themselves while at the same time trying to be the woman society dictates they should be.

Early childhood experiences develop inner resources and strengths, with feelings influenced by early relationships within the family. If girls' needs for close intimacy, nurturing, and love are met, they may develop inner resources that will decrease their vulnerability to depression later in life. Unfortunately, for some, baby girls may be seen as a disappointment, as second best.

Moss (1970), Maccoby and Jacklin (1974) and Belotti (1975) have discussed various reasons that some girls are not as valued as boys (cited in Corob, 1987). Some
girls lack encouragement and learn that they are not destined to be important individuals in the outside world. Some girls who are raised with traditional sex roles are deprived of a variety of experiences that would enable them to become strong, independent women. These girls may be taught that it is of the utmost importance to be clean and tidy, pretty and passive, coy and attentive of others, and to stay close to home. They may be taught not to take risks, so they do not develop a strong, independent, adventurous, assertive side. They may learn that love and approval are dependent on nurturing and giving emotionally, they may be conditioned to be submissive, to be what someone else wants, and they may decide that their sense of self-worth comes from relationships with others, meaning males. As adults, they may have learned that they should be passive, fearful, submissive, and self-sacrificing, which are core components of depression (Corob, 1987).

If girls who have been raised with these messages, and who have internalized them, are faced with situations that make them question these messages, they may become depressed.

The education system, books, and media reinforce and perpetuate this image of girls and women. The women who believe this image, therefore, are socialized to take on inferior, subordinate roles leaving them with a fragile sense of their own worth and power. The feminine characteristics and roles they are required to adopt from childhood on offer a limited range of actions and adaptive resources, which leave them more vulnerable to depression in times of stress. They are encouraged to aspire to false goals, expectations, and images that are defined by men and rarely attainable. With the constant barrage from the media, which is controlled by males, appearance is seen to be the lens
through which females are rated and valued. The image that is the most valued is the rarest; the thin, full breasted blonde with blue eyes and perfect features, and yet this is the one that is held up for females to attain. If women do have this image, however, they may never know if it is them or their looks that make them worthwhile. If they do not have this ideal look, they may feel empty inside as they cannot achieve it and are therefore a failure. And, if they reject the whole “looks game” then they may be seen as peculiar. All these feelings and self-doubts, when internalized, may contribute to depression (Corob, 1987; Narine & Smith, 1984).

From her study of adolescent girls, Gilligan (1982) has determined that the psychic seclusion from the public world sets the stage for privatization of women’s experiences and impedes the development of women’s political voice and presence in the public world. It disassociates their voice from experiences, the reality of their experiences is denied, and their feelings and thoughts become fabrications (Gilligan, 1982). During adolescence, girls may experience relational problems with parents, peers, and sex partners; difficulties with school successes, failures, and exams; unwanted pregnancy, unemployment, loneliness, and isolation, which when viewed as stressful, increase their vulnerability to depression (Corob, 1987). Adolescent girls may be taught that it is selfish to bring one’s voice into relationships and that their experience is not a reliable guide to know what they really want. It may be dangerous to say or know what they want as their thoughts upset others and they risk being abandoned or retaliated against. Girls who struggle against losing voice and against creating an inner division or split may have a large part of their self that is outside relationships, increasing the risk of depression (Gilligan, 1982).
While this is happening, girls may be taught that their life experiences are determined by their attachments to others. Nancy Chodorow (1978) has discussed at length how girls, being raised by women, are taught to be like their mothers. Women are frequently seen as giving unselfishly to their family, friends, and jobs. They are always giving, patient, self-sacrificing, cheerful, and comforting, and these qualities are seen as maternally inherent qualities. Mothers are also seen as sexless, and their needs are either not recognized or seen as unimportant. If girls are not like their mothers then they must be like the opposite of the mother, which is the sex object. As the sex object, women are considered men’s property; their bodies are just machines to be used and women’s own feelings do not count. The association between women’s bodies and machines is perpetuated by the media where women’s bodies are draped over cars, boats, and motorcycles to be sold. Women’s bodies are bartered in marriage, stolen by rape, and bought by prostitution. It is difficult for females to respect the sensuality of their own bodies when they are treated like this and these images, when they contribute to numbing women’s feelings also increase the risk of depression (Narine & Smith, 1984).

These contradictory images of women, none of which take into account women’s feelings, are oppressive. If women do not conform to these images, they may be deemed inadequate or peculiar. If they do conform, the ability to be themselves might be damaged. When women’s images are produced by others, they may be unable to assert their own needs, may feel they have no real choice than to go along with others, and may feel powerless and helpless. These feelings all lead to depression. Girls and women do not want to lose their sense of being female, but they also want to be strong and when these
roles are conflicted, they may become depressed (Narine & Smith, 1984).

When women are depressed they worry more, have an increased negative self-image, and this results in a vicious spiral of self-hate. Their feelings are expressed in what are described as "weak" ways, for example crying when they are angry, which in turn leads to labelling women as hysterical, overly emotional, or attention seeking. They are told that women are supposed to express their feelings, yet when they do, they are put down or ignored (Narine & Smith, 1984).

Researchers have consistently found that women who are abused are depressed or report higher rates of depressive symptoms (Agulier & Nightingale, 1994; Canadian Mental Health Association, 1987; Cascardi, O'Leary, Lawrence, & Schlee, 1995) and suggest that the level of depression increases with the severity of the violence (Cascardi et al., 1995; Gelles & Straus, 1988). Women who have been the victims of rape or incest show increased levels of depression, fear, mistrust, and guilt leading to marital and relationship problems, sexual difficulties, and self-directed negative attributions (Able, Becker, Skinner, & Treacy, 1982; Bernstein, Miller & Williams, 1982; Carlson & Quinca, 1989; Orbuch, Harvey, Davis & Merback, 1994). Women who have experienced abuse have lower levels of self-esteem, feel powerless, have higher rates of depression, and poor coping skills.

Intrafamilial abuse, neglect, and domestic battery account for most of the physical and emotional violence children experience (Carnegie Council on Adolescent Development, 1995; Horowitz, Weine, & Jekel, 1995; Koop & Lundberg, 1992) and home is the major setting for violence (Straus, 1974). Important factors that impact the
developing child include the type of violence, the pattern of violence, the presence or absence of supportive adult caretakers and other support systems, and, importantly, the age of the child (Pynoos, 1990; Schwartz & Perry, 1994). Many women who grew up in violent homes display symptoms of depression. Research has shown that women who are abused are depressed and that the level of depression increases with the severity of the violence (Canadian Mental Health Association, 1987; Cascardi, O'Leary, Lawrence, & Schlee, 1995; Gelles & Straus, 1988).

Biological Theories of Depression

Biological theories of depression are important to look at as they seek to explain depression through changes in hormones, brain chemistry, or genetics, thus seeing the causes as being outside the individual's control. There are, however, a variety of ideas regarding how biological factors actually contribute to depression. The basic assumption is that women are biochemically different than men, and it is this difference that leads to higher rates of depression in women. Hook (1996) suggested that biological factors contribute to depression in women, and that genetics, hormones, and neurotransmitters are causal factors. Halbreich and Lumley (1995) compared neurochemical and neuroendocrine functions in men and women and found gender differences in several areas. These findings suggest vulnerability to depression might be related to hormones that play an important role in mood and behavior.

In general, biological explanations for higher rates of depression in women have tended to focus on well defined hormonal changes. The assumptions are that changes in levels of female reproductive hormones provide a general model for women's increased
vulnerability to depression. However, these assumptions may not be warranted.

In preadolescent girls, depression is relatively rare but once girls enter puberty, rates begin to rise. The few studies that have examined mood in relation to hormonal changes in adolescence do not generally indicate direct relationships between hormone levels and mood in girls (Blehar & Oren, 1997). Female gender has failed to explain increased risk for a depressive episode once psychosocial and life-event variables were included in a predictive model (Blehar & Oren, 1997). It seems that girls' increased susceptibility to depression results from a complex interplay of biological, social, and developmental causes.

A significant number of women report moderate mood changes in relation to their menstrual cycle, with depression peaking in the late luteal phase (Blehar & Oren, 1997). Some researchers have proposed that late luteal phase changes may serve as a model for women's general vulnerability to depression. However, if this were the case, women would be at higher risk for recurrent mood disorders, yet the rates for both men and women are similar (Blehar & Oren, 1997).

Biological theories have also attempted to explain depression through changes in brain chemistry. One theory that gained prominence in the late 1960s and early 1970s was the “amine hypothesis of depression” and is interesting because it sees depression as occurring as a result of a defect in the function of specific central neurotransmitters. Amines are one type of neurotransmitter, a biochemical that facilitates transmission of impulses from one neuron to another. Amines appear to play an important role in the transmission of information between neurons in the limbic system, a part of the brain that
seems to influence emotion. The theory concludes that a loss of drive and negative emotions result from the depletion of amines in the limbic system, and are not a result of personal deficits. Depression, according to this theory, is due to a decrease in functional concentrations of noradrenaline and/or 5HT at receptor sites in the brain, and depressed people hypersecrete cortisol (Nolen-Hoeksema, 1990; Tipton & Youdin, 1989).

Depression, according to this theory, is seen primarily as a disease of middle and old age, with a median onset age of forty-two, affecting women more than men, is episodic in nature with no apparent environmental cause, peaks in the spring and fall, and spontaneously improves within six to eighteen months following onset. Support, however, for this theory has been mixed (Nolen-Hoeksema, 1990; Tipton & Youdin, 1989), and does not take into account women's social situation. It also does not correspond with the findings of Weissman (1995), who states that depression is experienced for the first time by both sexes in their mid to late twenties.

Another theory on depression is that the causes lie in heredity, thereby explaining why members of the same family may seem predisposed to depression. Kendler, Walters, and Truett (1995), after studying adult twins and their families, suggest that depressive symptoms are influenced modestly by heredity, and hardly at all by common childhood environments. The correlation for depressive symptoms was highest among identical twins, indicating a heritability (proportion of the variance, or individual differences explained by heredity) of 30-37%. Among fraternal twins, the correlation was about half as strong. Husbands and wives were about as highly correlated as fraternal twins, and this similarity did not become greater with more years of marriage. Kendler et al. believe this
resulted from assortative mating (the tendency to marry someone similar to oneself) rather than from mutual influence, however this has not been proved.

Another theory is that a genetic abnormality leading to depression is linked to x chromosomes that determine gender, as families with an immediate member suffering from depression are two to five times more likely to suffer from depression (Fromanek, 1987; Nolen-Hoeksema, 1990). If the gene for depression is located in the x chromosome and the trait is dominant, females, who have two x chromosomes, would be more affected. However, for both males and females, there is a high familial aggregation in major depression for first degree relatives. Genetic influences on depression, therefore, appear to be weak, and cannot account for the increases in depression for age cohorts born after World War II (Blehar, Weissman, Gershon, & Hirschfeld, 1988).

With the classification of different types of depression in the medical field, testing is complicated and the results are inconclusive and contradictory. Findings of progressive increases in the rates of depression, the onset at earlier ages, and shifts in the male to female rates cannot be explained by a single genetic predisposition factor (Fromanek, 1987; Nolen-Hoeksema, 1990). Research by Gatz, Pedersen, Plomin, Nesselroade, & Mc Clearn (1992) suggests that genetic influences account for only 16% of the variance in total depression scores, and that life experiences are the most statistically important influence on self-reported depressive symptoms. From this, it seems that genetic and environmental factors, together, may form a complex web that interact to increase a person's vulnerability to depression.

While biological theories may be useful for explaining some of the physiological
changes depression causes, they are not particularly helpful for understanding women's lived experiences with depression. They are, however, important to look at as depression is generally viewed and treated through the medical model from which women frequently feel alienated. The institution of medicine often acts as a social control, encouraging individual patients to look at themselves as the reason for their medical condition rather than assisting patients with looking at the larger social problems which may be contributing to their illness. Additionally, some doctors have discounted women's concerns, labelling them neurotic or hysterical or deciding their problems are all in their "mind". Women were treated with tranquilizers such as Valium or Librium for years, becoming addicted and unable to function without them. With the availability of antidepressant medicines on the market now, women are being prescribed these medications instead of tranquilizers. Some doctors only treat their patients with medication and do not refer them for counselling to deal with the underlying issues behind their depression. Those who are referred for counselling have few choices unless they have the funds or extended health benefits to pay for private therapy, and must see a psychiatrist as they are the only counsellors covered by medical services. Unfortunately, the psychiatrists also work from the medical model, generally viewing depression as an individual problem, and treating patients primarily with medication. Additionally, some doctors and psychiatrists frequently treat women as passive sufferers of depression that they, as the experts, cure, and there is a deeply embedded power imbalance. By pathologizing women's problems medical models reinforce women's depression as an individual problem and perpetuate and legitimate adverse social conditions (Corob, 1987).
Behavioral Theories of Depression

Behavioral theories view depression as being caused by insufficient reinforcers and not enough rewards for behavior. Seligman (1975) developed the theory of learned helplessness, and originally proposed that when people are denied the opportunity to control their environment in their early years they learn that their actions have no effect on the consequences. After a time, they cease to act as there seems to be no point if there are no rewards, and so their behavior becomes a vicious circle (Corob, 1987; Narine & Smith, 1984).

Seligman modified his original theory because there was little evidence to support the idea that chronically depressed people had experienced such a pattern of failures, and because research suggests that a person's appraisal of a situation is often more important than the objective nature of the situation (Ridley, 1978). He revised his theory to include the subjective interpretation of situations over which the person has no control, so it was not uncontrollable outcomes but the person's causal explanations for these outcomes that determine the degree of depression. When situations occur, the person will review similar situations that have occurred in the past and attempt to explain the event. If the explanation leads the person to conclude that she cannot control the situation in the future, symptoms of helplessness may follow. The learned helplessness theory, however, does not address how feelings, thoughts, and experiences influence behavior. It is also not clear whether negative thoughts precede or accompany depression. Does negative thinking lead a person to become depressed, or once a person is depressed, do they start thinking negatively? This theory also provides no social perspective (Corob, 1987; Jack,
Beck (1976) developed cognitive behavioral theory, which states that mood creates thought and pessimistic, negative moods cause depression. Beck's theory is different from Seligman's in that Beck proposes that negative thoughts precede depression, and are the cause of it. He suggests that individuals who are prone to depression have developed a general attitude of appraising events from a negative and self-critical viewpoint. Rather than expecting to succeed, they expect to fail, and they minimize successes and magnify failures when evaluating their performance. They also tend to blame themselves rather than their circumstances when things go wrong. Beck theorizes that if people learn new ways of behavior, their mood will change. Proponents of the cognitive theory of depression assert that it is not necessarily what happens to people that cause them to be depressed, but rather what they tell themselves about what happens. Examples of common thinking patterns that can lead to depression include overgeneralized thinking, perfectionist thinking, and the tendency to catastrophize.

This theory, however, fails to take into account historical factors or sociological perspectives, and there is no political or social understanding of behavior (Corob, 1987; Jack, 1991; Narine & Smith, 1984). This theory does not address how social factors influence mood, behavior, and thoughts. For example, when women are faced daily with the threat of violence, sexual assaults, rape, domestic violence, medical violence, and are treated as subordinate, second class citizens, it is no wonder that their moods and thoughts will often be pessimistic and negative. If all people were equal, perhaps this theory would be explanatory. As it is, it reinforces the idea that there is something wrong
with individual women rather than with the society they live in.

Summary

While an understanding of physiology is necessary to complete the picture of depression in women, it is important to appreciate its limitations in answering questions regarding women's health and behavior. This perspective does not look at how women are affected by depression. Cognitive behavioral theories state that distorted thought processes predispose women to depression. Without looking at women's behavior in the context of their social situation and cultural history, however, women's experiences may not be fully understood. Traditional developmental theories have frequently ignored the fact that women's development may differ from men's, and failed to look at how it differs.

The behavioral and developmental theories have frequently ignored the sociocultural context of women's experiences. In addition, the preferred treatment for depression, following these theories, is office visits with an inherent power imbalance and an "expert" cure. If women had more power, then perhaps they would experience less depression.

While there have been biological and epidemiological studies, there has been a lack of basic research on women's experiences of depression. This once again silences women, leaving them questioning the normalacy of their experiences. Little information has been offered on the imaginings, feelings, and patterns of thought of women (Jack, 1991), and this information could provide women with a framework for understanding their experiences.

Due to the limited research on women's own accounts of their experiences with
depression, a qualitative design for this study has been chosen, which allows for an in-depth exploration of the question: How do women, between the ages of twenty-five and forty-four, describe their experiences with depression? A phenomenological, exploratory, descriptive approach assumes that women are reliable witnesses of their own psychological experiences, and women's accounts of their experiences will give depth to our understanding of women's depression. The next chapter, methodology, explains in detail the research process that was utilized and introduces the six women who participated in this research.
CHAPTER THREE

Methodology

Research Design

Qualitative research methods are utilized to explore life experiences from the perspective of the participants and everyday life is examined in natural and uncontrolled settings (Morse, 1994). These methods enable one to "uncover and understand what lies behind any phenomenon about which little is known" (Strauss & Corbin, 1990, p.19).

In this case, it is the lived reality of women suffering from depression that is being explored. The literature review revealed that research in this area is limited. To this end, qualitative research is the most appropriate vehicle, using a phenomenological approach.

Phenomenology is both a philosophy and a method (Beck, 1992; Morse, 1994). Phenomenology began with the subject of consciousness and experience, and was then expanded to include the human life world and human actions (Kvale, 1996).

Phenomenology seeks to understand the lived experiences and intentions of individuals and the discovery of their essence is the main purpose of such research (Morse, 1994). As the layers of meaning are peeled away, what is left is the world perceived prior to interpretation and explanation (Beck, 1992).

Kvale (1996) describes a phenomenological method that includes description, investigation of essences, and phenomenological reduction. According to Kvale, phenomenology is the attempt to give a direct description of the experience without any considerations of the cause of the experience. In investigating the essences, the focus shifts to searching for the common essences of the experience. Kvale (1996) states "that
which remains constant through the different variations is the essence of the phenomenon" (p. 53). Phenomenological reduction involves a critical analysis of one's own presuppositions so that an unprejudiced description of the essence of the phenomena can be arrived at (Kvale, 1996). As the intent was to describe women's experiences with depression, without predetermining the cause of the depression while searching for the essence of the women's experiences, and through analyzing my own presuppositions so that an unprejudiced description could be arrived at, phenomenology seemed the most appropriate approach to inform this study.

Methods consistent with an understanding of feminist research and application to methodology were utilized as feminist analysis examines power and inequalities and provides a framework for understanding women's experiences. Feminist research challenges conventional viewpoints relying on masculine categories which exclude women's perspectives, and are distorted and biased in ways that account for social reality (Forganis, 1994). This seemed the most appropriate approach as the purpose of this research was to explore women's experiences with depression, from their perspective.

While there is a general agreement as to the need for feminist research, there is an ongoing debate within feminist writings whether or not distinctive methods exist. Riger (1992) and Cancian (1992) suggest there may be some common values that constitute feminist methods. Cancian (1992) identified five elements as principles underlying feminist methodology. These are the need to focus on gender and equality, qualitative research methods, research for women meaning that the research explores a phenomenon from women's viewpoints, critiquing existing research which frequently ignores or silences
women's experiences, and using participatory methods where women are not subjects but actively participate in the research process. Riger (1992) recognized the interdependence of the researcher and participant, the need to avoid decontextualizing the researcher and participant from societal and historical contexts, the need to recognize and reveal the nature of one's values within the research context, the need to accept that facts do not exist independently of the production of linguistic codes, and the need to demystify the role of scientist and establish egalitarian relationships between science makers and consumers. Riger postulates that a woman listening with care and caution enables other women to develop ideas, construct meaning, and use words to say what they mean.

These values informed my research as my intent was to give voice to women's experiences and to this end, when I first talked to the participants about becoming involved in the study, I explained that I had experienced depression. I also explained that as I talked to other women about my experiences, I found that many other women were also experiencing or had experienced depression and wanted to talk about their experiences, and that women's depression seemed to be much more than an individual woman's problem. I discussed how this had led me to question what was happening for women that so many of us seemed to be suffering from depression, and to wonder how depression had impacted other women's lives. I discussed how the purpose of this research was to gain a deeper understanding of women's experiences with depression as we had information on rates of depression, causes of depression, and treatment for depression, but not on women's actual lived experiences with depression.

I explained that I was utilizing a feminist perspective, which included looking at
gender and equality, because I felt that these issues impacted women's depression. I explained that I was utilizing qualitative research methods, which involved having unstructured interviews, so the women could talk about their own stories in their own words in a way that made sense to them. My aim was to give voice to women's experiences that had previously been ignored or discounted, which is consistent with feminist research. I discussed what some of the literature said about women's depression and about women's lives so that the women would understand why I was using a feminist approach. I also talked about how language shapes our thoughts and understanding. For example, the word chairman has only changed in recent years to chairperson or chair as it is no longer taken for granted that the chair is a man, but could be a woman. Also, when we talk about women's roles what first comes to mind for many people is wife and mother, rather than defining women by their employment role, and if we talk about women in the work place it is traditional women's jobs such as teacher or nurse rather than doctor or mayor that also often come first to mind. I wanted to share how I thought language shapes our thinking to uncover some of the preconceived notions about women and depression.

My purpose in discussing these issues with the women who had agreed to participate in the research, but before the first interview was held, was to let them know what my values were, such as coming from a feminist position, and how I felt that women's experiences had been ignored or discounted in much of the current research. My intent was also to start building a trusting relationship through sharing some of my experiences and values so the women would feel more comfortable sharing their stories.
To demystify the research process, I explained to the participants what was involved at each stage of the process. I discussed how I had researched the literature on depression to understand what was already known. I explained the methods I was going to use; how the interviews would be unstructured, that they would be taped and transcribed verbatim. I also talked about the analysis and the different methods that I was considering using but how this would not be determined until the interviews were finished. I explained that the women would receive copies of their transcripts so that they could make any changes and would have final say over anything they did not want included in the thesis. The purpose was for the women to understand that we were working together to provide women, social workers, and other service providers information and insight, through the findings in this thesis, into women's experiences with depression.

In keeping with feminist research, a participatory research format was utilized. Reinharz (1992) states that

In participatory or collaborative research the people studied make decisions about the study format and data analysis. This model is designed to create social and individual change by altering the role relations of people involved in the project. The model can be limited to a slight modification of roles or expanded so that all participants have the combined researcher/subject role. In feminist participatory research, the distinction between the researcher(s) and those on whom the research is done disappears. To achieve an egalitarian relation, the researcher abandons control and adopts an approach of openness, reciprocity, mutual disclosure, and shared risk. Differences in social status and background give way as shared decision-making and self-disclosure develop (p.181).

This model is most effective in emancipating participants when researchers self-disclose, multiple interviews are conducted, and there is negotiation of the interpretations. This shaped the structure of my research so I included all the participants in all the research
processes that they chose to be included in. This involved shared decision-making and self-disclosure.

I disclosed that I had experienced depression, prior to the first interview, but did not go into any detail about how that experience had been for me. After the first interview, I shared some of my experiences and what that had been like for me. I did not want to share my experiences before the first interview because I did not want the participants to think that I was looking for experiences that mirrored my own. I wanted their experiences, in their own words, with their own understanding. The aim of this process was to build trust and give a sense of a shared undertaking rather than having the participants as subjects and the researcher as the "removed" expert.

Once the research design had been determined, ethics forms (see Appendix A) were submitted to the University of British Columbia Ethics Committee for approval. Included with the ethics form was a copy of the participant consent letter (Appendix B) and the interview guide (Appendix C). Originally, the participants consented to one interview, but as they became involved in the process were interested in participating in additional interviews and the analysis.

**Sampling Design**

The researcher must consider a variety of different components when selecting the sample -- the choice of a particular population, the size of the sample, and the rationale for the sample selection. Marshall and Rossman (1995) state that well developed sample decisions are crucial to any study’s soundness. Appropriate procedures and criteria for a particular selection are required to develop a meaningful feminist, qualitative study. This
research project is qualitative and exploratory in nature, and the purpose is to learn from and give voice to women’s experiences with depression, to explore their stories about how depression has impacted their lives and vice versa, and the supports and services that they feel need to be available to women suffering from depression.

The population accessed for the research were women between the ages of twenty-five and forty-four because, according to researchers Jack (1987) and Weissman et al. (1981), women between these ages are particularly at risk for depression. Additionally, women under twenty-five are often experiencing major life changes such as leaving home for education, marriage, or jobs and may be starting careers or families, which all increase stress. Women over the age of forty-four may be experiencing hormonal changes, which affect depression. Because I wanted to gain a deeper understanding of women's depression that was not necessarily related to hormonal changes, I decided to exclude women over forty-four, and women experiencing post-natal depression. Although the women may have experienced depression as children or adolescents, I chose women who described themselves as being depressed or having been depressed as adults. I also chose women who spoke English, were able to understand the purpose of the research, and who were able to give consent. The women had to reside in the Lower Mainland of British Columbia as I was not able to travel for interviews, and I did not feel that telephone interviews would elicit as rich information as body language would be missing.

Snowball sampling, using the third party approach, was used to recruit participants. Women, who knew women who described themselves as being depressed, either now or in the past, were asked to give my name and telephone number to these
women. Nine women responded, and the women who fit the above criteria were then asked to participate as the phenomenological, descriptive approach assumes that women are reliable witnesses of their own psychological experiences (Jack, 1991).

In-depth interviews were conducted with a sample of six women as this was a manageable size to conduct in-depth interviews. Morse (1994) has recommended that phenomenological research should include about six participants for discerning the essence of experience. Given this, I determined that six participants, with multiple interviews, would allow for sharing results and including further ideas and input. Six participants were a manageable number, given my time constraints, the fact that all the women I talked to had busy lives, and between two and seven interviews were held.

Research generally tries to ensure that a diverse population of races, classes and cultures participate, but it is recognized that with a small population this is not possible. Two of the women who participated in the research were of First Nations heritage, and the other four were of various European descent. This sample takes into account some of the cultural background that may have impacted the two women of First Nations heritage, but omits women's experiences that may have been shaped by various other cultures. It is recognized that women from other cultures and races may have different experiences with depression. All of the women were low to middle class, although two of the women had grown up in poverty. One of these women also fluctuated between being on Income Assistance and working. It is recognized that women living in poverty may also have different experiences with depression. The primary focus for this study was to obtain participants for an in-depth study to provide rich and valuable information about
individual experiences of depression. In this case the women's stories provided this information, and this sample achieved that purpose.

It is also particularly important to validate the findings in qualitative research because the researcher is often "working alone, without any standardized or validated instruments ... [running] the risk of overgeneralizing" (Miles & Huberman, 1984, p.230) or drawing false conclusions based on researcher bias. Verifying the findings through follow-up interviews adds to the validity of the research (Miles & Huberman, 1984), and honors women's experiences by not imposing interpretations of those experiences. I conducted at least one follow-up interview with all six of the six women, and conducted between four and seven interviews with five of the women. These five women also had input into developing the categories that conceptualized their experiences and agreed that the themes accurately depicted their experiences with depression.

The Participants

I would like to introduce the women who shared their experiences with me. All the participants chose alias names to protect their identity and to ensure confidentiality. All of them preferred to be mentioned by name rather than a code or other differentiating number.

The six women who shared their stories so openly and honestly were Andie, Tammy, Sasha, Mary, Tina, and Megan. As the women told their stories, I was deeply moved by their courage and integrity, and their willingness to risk themselves in the hopes that sharing their experiences might help other women struggling with depression.

General background information will provide an introduction to these women as a
group without revealing their identities. Originally, brief vignettes were written to introduce the women, but they felt these vignettes revealed too much about their identity, so a general introduction was agreed on. The six women in this study ranged in age from twenty-five to forty-three; five were employed full-time although one of these women is frequently unemployed and on Income Assistance, and one woman had recently entered, for the first time, the work force on an on-call basis; one of the women had a university degree, two had diplomas, one was attending college although she had dropped out of school in grade seven, one had taken some specialized training, and one had completed high school; two women were of First Nations ancestry and the other four were of European descent. One woman was single, one was living with a male partner, and four were married, although one of them described herself as being bi-sexual. One of the married women had three children ranging in age from twelve to eighteen, another of the married women also had three children, ranging in age from fifteen to twenty-one, another of the married women had two children ranging aged seventeen and eighteen, and the last married woman had a seventeen year old and two older step-children aged nineteen and twenty-one. Although there were commonalities between the women, there were also many differences in experiences.

Two of the women had been sexually abused as children, three had grown up in alcoholic homes where they experienced physical and psychological abuse, and one grew up in what she described as "an emotionally abusive home." All of the women described growing up in homes where feelings were not discussed or dealt with and where they learned to put on an "acceptable public face." Three of the women described having
periods of depression from their childhood to the present while the other three had only experienced depression as adults. One of these women was able to place the initial onset of her depression as the result of a car accident. Four of the women felt that they had strong support networks and relationships, while the other two women felt they lacked close supportive relationships.

At the time of the interviews, four of the women described themselves as being depressed while the other two women described themselves as free of depression. The four women who described themselves as being currently depressed had a difficult time starting their stories, and required more open ended questions such as "Could you tell me more about what that meant to you?" at the beginning of the interview. However, for all of the women talking about their experiences was extremely emotional, involving both tears and laughter.

Miles and Huberman (1984) have discussed reducing the effects of the researcher on site, so to ensure the participants were as comfortable as possible, they were asked where they would like the interviews to take place. Three of the interviews were conducted in my home, two were conducted in the participants homes, and one in the participants office. The information obtained and the length of the interviews was similar in all cases as all the women talked about both their current and past life stories which took approximately two to two and a half hours.

Data Collection

Interview methods, the number of interviews, the duration and researcher participant relationship are all practical details that must be attended to by the researcher.
In-depth interviews were held with each of the participants. From a feminist perspective such interviews offer "access to people's ideas, thoughts, and memories in their own words" (Reinharz, 1992, p.19).

The researcher must also identify and discuss potential ethical dilemmas that may emerge and affect the data collection. To accurately reflect women's experiences, an unstructured format with open ended questions such as "What have been your experiences with depression?" and "What circumstances do you think have impacted your depression?" were used. The purpose is to hear the ideas, thoughts, and feelings as expressed by the women themselves. The primary orientation for feminist interviews is the validation of women's subjective experiences as women and people (Oakely, 1981). Chernomas and Rainon (1994) state that the systematic recording of women's descriptions of experience is best achieved through multiple, in-depth interviews with smaller samples, conducted over time, and with a variety of open ended and focused questions. Multiple interviews establish strong researcher participant relationships, build trust, and allow for sharing transcripts, viewpoints, and analysis. More in depth information causes the researcher to ask more questions or ask for clarification (Reinharz, 1992).

I conducted multiple interviews to expand on the information acquired in the first interview, to ensure accuracy in recording information, to build trust, and to form a bond with the participants. Multiple interviews are characteristic of much feminist research because it helps form strong bonds between the participant and researcher, develops trust, and provides the opportunity to share transcripts and invite the participants analysis.
(Reinharz, 1992). Additionally, Reinharz states that multiple interviews are likely to be more accurate than single interviews because of the opportunity to ask additional questions and get corrective feedback on previously obtained information. It has also been found that research designs can change people by encouraging self-reflection, facilitating a deeper understanding of their situations (Lather, 1988) which was my hope through conducting multiple interviews and inviting participant analysis of the research.

Five of the women participated in between four and seven interviews, while one woman participated in two interviews. The first interview was to listen to the women's stories and record them, and the second interview was for the women to read their transcript and make and changes, additions, or deletions. I talked to all the women before giving them their transcripts about how taking their stories and transcribing them verbatim made them somewhat difficult to read. I explained that we do not speak the way we write, so we might have a variety of feelings when we read exactly what we have said. I also explained that reading their stories could be difficult for them as they saw what they had said in print.

With the woman who participated in the two interviews, the first was to listen to her story and record it, and the second was for her to read the transcript and make any changes, additions, or deletions. When she read the transcript, she asked that some identifying information be removed, and provided additional information about her family of origin. Notes were made on the transcript of this additional information, and included in the analysis. This woman did not feel that she could give any more time to the research as she was leaving town for a time, and was satisfied that the transcript accurately
depicted her experiences. She was amazed that she had said so much about her experiences and felt "good" about the information she had chosen to share.

With the other five women, the first and second interviews were similar to the first woman. All of the women commented that they sounded "nuts" when they read exactly what they had said, and laughed over way some of them sounded. Four of the women found it difficult to read some of their story, and talked about how different it was seeing it in writing. This was a surprise to them even though we had talked about it, but it seems that it is very different talking about yourself and reading about yourself. All of the women but one also had some identifying information they wanted removed from the transcript. Additionally, one woman wanted some information about family members removed as she was not sure if it was accurate or not.

After reading the transcript and discussing it, five of the women wanted to discuss specific areas in more detail. This came about as they looked at what they had said relating to family, abuse, sexuality, culture, and help. These interviews were also recorded and transcribed, with the full transcriptions being included in the analysis. One of the issues that all the women talked about were their experiences with their family of origin. As this issue seemed to have had an effect on them all, it was an area that we decided to explore in more depth in a subsequent interview. For one of the women, this was followed by another interview where she discussed how her sexuality had affected her relationships not only with her family, but also with her daily life. Another interview was held with all five women to explore, in more depth, their feelings surrounding abuse they had experienced and how this had impacted their depression. The two women who were of
First Nation's ancestry also participated in an additional interview where they explored what this had meant to them, and how they felt it contributed to their depression. A final interview was held with all five women to explore their ideas on what changes they felt needed to be made to help women suffering from depression. In addition, the five women who participated in multiple interviews also participated in interpreting the data to develop the themes, categories, and sub-categories.

Through building a relationship, over time, with these women, the information obtained in subsequent interviews was richer than that obtained in the first interview. As trust was established, the women felt more comfortable sharing intimate details of their lives. This led to them discussing parts of their lives that they had only alluded to at the beginning of the process, providing a more comprehensive picture of what the experience of depression had been like for them. In addition, returning the transcripts enabled the women to have control over the interpretation, which also elicited further information as they discussed some of the meaning behind what they had said. This is in keeping with the research on feminist multiple in-depth interviewing discussed by Reinharz (1992).

Interviews were conducted with the women deciding how long they could devote to each interview and how many interviews they wanted to participate in. For example, given their schedules, did each woman feel that she could only participate in one interview and the follow-up for ensuring accuracy of information that was transcribed, or did she want to discuss additional information, or explore an area in more depth (see Appendix C for the interview guide). It was explained that the interviews would probably last at least an hour and a half, but could be shorter or longer depending on how much the women had
to say, or how stressful the interview was for them. The women were told that they could determine the time limits of the interviews depending on their time constraints, ie. other meetings, commitments, or how they were feeling about the interview. The women were told they could stop the interview at any time, and participate in as many interviews as they felt necessary to ensure their story was told and interpreted accurately.

The interviews were non-hierarchical which was accomplished by explaining that I was not an "expert" and was there to listen to their stories, providing the participants with information on the process, asking the participants where they would like the interviews to take place, and ensuring their comfort level by providing refreshments, kleenex, and breaks. Oakley (1981) suggests generating an approach where the researcher and participant are engaged in a joint enterprise. To this end, the interview procedure was explained to the women. They were told that what we were doing was having a fairly one sided conversation where I might ask questions for clarification or expansion. The purpose of the research, which was to explore women's experiences with depression, was discussed. I explained that my role was to listen to their stories, make available referrals if they felt the need for follow-up, and ensure their comfort level through having the women determine the location and length of interview. The participants were told that they were not obliged to answer any questions and could discontinue their participation at any point. Confidentiality was discussed, and the women chose aliases to be used in the transcript.

The interviews were held at locations of the participants choice, and lasted approximately two to two and a half hours each but were flexible. Each interview, except the second follow-up interview, was audio taped. Permission given by signing a consent
form (see Appendix B) prior to the start of the first interview, and then verbally at each subsequent interview. An explanation of the consent form and the purpose of using audio tapes was provided, as well as the opportunity to refuse to be taped. The participants were provided copies of the transcripts to elicit feedback, add or omit information, and enhance credibility.

Being listened to elicits strong feelings and emotions, and the researcher must remain sensitive to this fact. This may create a dilemma if they look to the researcher for answers and support. While Oakley (1981) and Reinharz (1992) suggest that answering women's questions enhances further sharing, there is a difference between research and therapy. Feminist methodology advocates that intimacy, openness, and developing a close relationship are an important balance in differing the therapeutic from the therapist. To this end, I was open with the participants about the research process and discussed my experiences with depression. Intimacy was built through listening to the women's stories using empathy and reflecting back feelings, and sharing my story. Honesty, empathy, and acknowledgment of feelings are all essential components for a safe, trusting relationship. The women all verified the comfort level the end of the interview when we were discussing how the interview had been for them, and stated that knowing I had experienced depression felt safe sharing with me. While it is recognized that there is therapeutic value in talking, talking about painful experiences may be distressing. To ensure that all women received support or counselling they required, a list of counsellors available in their area, and a list of community resources were available to all participants. Although none of the women felt they required this information at this time, all of the
women took the information because they thought it might be useful in the future.

**Data Analysis**

The interviews elicited a wealth of information about the six women's' experiences, and five steps are involved in phenomenological analysis (Kvale, 1996). The first step is to read the total interview to get a sense of the whole picture. The second step is to determine the meaning of each "unit" as expressed by the participant. The third step is to state, as simply as possible, the central theme that dominates each unit. The fourth step is to look at each unit in terms of what does this tell me about the question, in this case women's experiences with depression. The fifth step is to tie together the essential, nonredundant themes into a descriptive statement. This method of analysis, therefore, involves condensing the expressed meanings into more and more essential meanings of women's experiences with depression (Kvale, 1996). This enables the researcher to condense the bulk of the data into analyzable units by creating categories with and from the data (Coffey & Anderson, 1995).

To draw out, compare, and summarize the main themes, each woman's story was analyzed individually and was then compared to the other women's stories. All audio tapes were transcribed verbatim (for a sample of a complete interview transcript see Appendix D). The first part of the analysis was recognizing that each woman's experience was different and seeing how each woman made sense of her experience. The second part was searching for similarities and differences across their experiences and identifying themes that potentially could contribute to theory development.

To achieve this, each woman's story was analyzed and then compared to the other
women's stories. Within the given field of inquiry, there may be family resemblances
between different stories. By comparing and contrasting examples, rules can be formed,
and categories can be developed which gradually systematize the facts and theories gained
from the intensive study of individual examples. Theory emerges through a process of
conceptual refinement as successive examples are considered in relation to each other (Bromley, 1986). Reinharz (1992) states that there are:

three major purposes for feminist case studies - in addition to
generating and testing theory - are to analyze the change in a
phenomenon over time, to analyze the significance of a phenomenon
for future events, and to analyze the relation among parts of a
phenomenon” (p. 164).

Individual stories can be combined to enable the examination of the relationship between
them and particular social structures and processes, and to search for specificity,
exceptions, and completeness rather than generalizations.

Prior to analyzing the information, I had transcribed the tapes, read and reread
each transcript, and listened to the tapes from each interview many times over, until I felt
that I knew each woman's story intimately. I spent time considering the information from
different perspectives, and looked for emerging patterns. At this point, I felt that I was
able to identify the emerging themes and could have proceeded with the analysis.

However, five of the women had stated that they would like to participate in the analysis,
and felt that sharing their stories and getting to know one another would be helpful for
them. All six women stated that they were comfortable having the other participants read
their transcripts, and it was agreed that personal information would not be discussed
outside this group.
Before we sat down to start the analysis, I talked to all of the women who were going to participate in the analysis. At this point in the process, I saw my role as a teacher. I explained how we were going to analyze the data, that we would read each transcript line by line to look for themes and categories. We would be looking at the context in which each woman's story was told, to make sense of her experiences, and we would also be looking for what the woman did not say. I also gave the women information to read on phenomenological analysis.

Once the women felt prepared, we got together as a group. Each woman's transcript was read line by line to identify the themes, categories, and sub-categories. This involved five of the women and myself sitting down with each transcript and deconstructing each story for what it said, what it did not say, and what it might have said. We looked for specificity, exceptions, and completeness in each story, taking into account the social and historical context. Memos were written, identifying the points, by each of us. Once we had an initial picture, we went back through the information with this list of points. We noted any new information that supported or contradicted these ideas. We looked at stories, metaphors, feelings, and particular uses of language to analyze the information.

The phenomenological method of analyzing and abstracting the data, which involved reducing units to descriptive statements in each transcript, comparing them looking for similarities and differences, and redescribing them, produced three themes, which reflect the overall experiences of the six women's journey through depression (see Table 1, Chapter 4). Each line or segment of the transcript that related to a particular
category was cut out of the transcript and placed in an envelope labelled for that particular category. Five of the participants were involved in this process, presenting ideas and discussing the accuracy of the themes and categories as they arose. There was not always agreement when a woman presented her ideas on a theme or category. When this happened, we took the information back to the transcript to look at the context in which it had been provided. In addition, the woman who had provided that information talked about what it meant to her. The other women then talked about similarities or differences with their information, and it was discussed until a consensus was reached. There was not a lot of disagreement in this process as taking the information back to the transcript for the larger picture seemed to assist with clarification of meaning, and the women found that their feelings were similar even when their experiences differed.

The information that had been produced from the follow-up interviews was also included and analyzed in this same manner. Once the categories emerged, and the participants felt that the categories accurately reflected their experiences, the data in each category were again analyzed to define the sub-categories. Again, the five participants were involved, proposing ideas until they felt that the sub-categories also accurately reflected their experiences, with the same process utilized as in the earlier analysis. The whole analysis was a lengthy process, involving six meetings of approximately four hours each.

The participants involvement ensured that the analysis accurately depicted their experiences and was not a result of my analysis of my own experiences with depression. I did at times, however, share my experiences and what they meant to me to generate
discussion about the data. It is recognized that alternate methods of analysis, or not including the participants may have resulted in different themes and categories arising. However, this method, I felt, honored the women's stories and validated them as being reliable witnesses of their own experiences. An in-depth exploration of the categories and themes is explored in Chapter Four where the results of the analysis are discussed.
CHAPTER FOUR

Results/Discussion

Themes

Analysis of the transcripts revealed that women's experiences with depression are a complexity of events depicted by three overall themes: a) Losing The Self, b) Searching for Meaning, and c) Regaining The Self.

Losing The Self captures the essence of the women's experiences of being depressed. The women talked about the physical and emotional changes they went through, and the feelings these changes gave rise to. The following categories: Going Crazy, Cut-Off, and Alienated gave rise to theme one. Searching for Meaning describes the importance the women attached to making sense of their experiences. This search was both internal and external as they looked at their family of origin, their chosen family, abuse and control issues, experiences with friends, and messages about what it means to be female. The following categories: Lack of Control, Nobody Understands, and Who Am I gave rise to this theme. Regaining The Self describes the women's healing journey. The women discussed what they needed, whom they needed it from, and how. The following categories: Opening Up, Finding a Balance, and Making Changes gave rise to this theme.

The themes, categories and sub-categories are shown on the following page as Table 1.
**TABLE 1 - THE EXPERIENCE OF DEPRESSION**

<table>
<thead>
<tr>
<th>Sub-Categories</th>
<th>Categories</th>
<th>Themes</th>
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<tbody>
<tr>
<td>Feelings</td>
<td>Going Crazy</td>
<td>Losing The Self</td>
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<tr>
<td>Physical and Cognitive Symptoms</td>
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<td></td>
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<tr>
<td>Relationships</td>
<td>Cut Off and Alienated</td>
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<td>Suicide Attempts</td>
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<td>Wearing a Mask</td>
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<tr>
<td>Childhood Messages</td>
<td>Lack of Control</td>
<td>Searching For Meaning</td>
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<td>Abuse</td>
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<tr>
<td>Genetics</td>
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<tr>
<td>Family Pressures</td>
<td>Nobody Understands</td>
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<tr>
<td>Experiences With Friends</td>
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<tr>
<td>The Perfect Woman</td>
<td>Who Am I</td>
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<tr>
<td>Society's Expectations</td>
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<tr>
<td>One Accepting Friend</td>
<td>Opening Up</td>
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<td>Professional Supports</td>
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<td>Medication</td>
<td>Finding A Balance</td>
<td>Regaining The Self</td>
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<td>Self-Help</td>
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<tr>
<td>Education</td>
<td>Making Changes</td>
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<td>Women Supports</td>
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<td>Free, Accessible Counselling</td>
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</tbody>
</table>
Categories

Each category reflects a set of common experiences encountered by the six women in this study. Exploring these categories will enable the reader to follow each woman's journey through depression, and the struggles they still face. The descriptions of their experiences, quoted directly from the transcripts, provide an overview of the experience of depression illuminating the themes generated from these women's stories.

Losing The Self

The first theme, Losing The Self describes the women's experiences with depression. The women felt they were "being sucked into a grey hole" where no matter how they tried, they could not escape. They found themselves crying, for no apparent reason, and were unable to stop it. They could not identify what was wrong, and found themselves withdrawing from the world because they could not bear the pain and could not explain it or make sense of it. As this was happening, the women "shut down and deadened their feelings." They did not know what to do, "nothing seemed to help, and so I cut off from myself and others. I didn't know who I was anymore." Each woman talked about the different feelings she experienced and the physical and emotional changes she went through, which gave rise to the categories going crazy and cut-off and alienated.

Going Crazy

Going crazy describes the women's feelings of losing themselves and being unable to control how they were feeling or what they were experiencing. The women talked about being afraid that they were losing their minds, and not knowing what to do to stop the process.
Feelings. The overall feeling the women experienced was one of losing control of themselves. They felt they should be able to control their feelings. They knew there was something wrong, but did not know what, and did not know what to do to change it. The women did not attribute most of the feelings and changes, at the onset, to depression but realized later that these were symptoms of the depression. They attributed their feelings to stress or burn out, which were acceptable. All the women equated depression with mental illness, so the idea that they were depressed did not even enter their minds at first. The feelings were overwhelming for them and they often felt split between how they felt and how they seemed to be to other people.

Just the auditory, the body parts, my emotions. I was very emotional. Very emotional, either with my family at home, little things would set me off crying. I can remember being up at night in my room, crying, and just not knowing why. What's going on, what's wrong with me, why am I falling apart. You seem to be fine, you seem to be okay, but you're not, you're obviously not. You can't deal with it. So a lot of hiding going on with yourself. - Tina

All of the women talked about feeling "down," crying, and withdrawing from other people. They all felt they had lost control, and lost themselves. The other symptoms that all the women shared were a lack of energy, mood swings, sleeplessness, forgetfulness, irritability, and an inability to concentrate. Megan describes these symptoms of depression as:

this horrible, grey swirling mist of despair where everything feels dead, but you don't know what's wrong. Everything is a struggle. You cry. You snap at people. You think that if you could just figure out what's wrong, then you could fix it, but you don't have the energy so you just sink deeper and deeper into this hole. It's really scary, and you think you're going crazy, losing your mind.

As the women experienced these symptoms of depression, they felt that they should be
able to control how they were feeling. All of the women thought of themselves as strong people and that there must be something that they were doing (or not doing) that was producing these symptoms. To try to stop the way they were feeling, the women became increasingly more involved with activities. They loaded on more so that they would not have time to think or feel. Unfortunately, the more they tried to do the more fractured they became, resulting in the women feeling that they were totally losing themselves, and that they had lost control of their lives.

I thought that I would just wake up one day, years from now, in an institution, and my kids would have grown up and I would have missed my life. This was really scary. I went between being numb and terror but I didn't know what else to do. I knew what I was doing wasn't working and that was when I decided I had to get help. - Megan

None of the women identified herself as being depressed at the onset of her symptoms. Sasha was able to identify within a few weeks that the symptoms were signs of depression, while the other five women did not recognize this until they were no longer able to function at work or at home. It was not until the women realized that they were depressed, which in all but Sasha's cases was identified by someone else, that they recognized that what they had been experiencing were symptoms of depression. While the literature states that women are more likely than men to be aware of their feelings and seek help, all six of the women thought that she should be able to handle things herself and five of the six women did not seek help until they were no longer able to function in their daily lives. This may have been in part due to the issues surrounding control, the need to always be in control, and in part due to the difficulties the women had in disclosing their feelings to others.
Physical and Cognitive Symptoms. The women all talked about physical changes they experienced through the depression.

I would shake all of a sudden. It was a really weird feeling I can't explain. It was almost like it started from my feet ...I can't explain the feeling. It's just like your body is out of control, you started to shake and you got this feeling in your stomach and it wouldn't go away, and it went right through...I tried to stop it, I tried to stop it, and it wouldn't go away, and then I would just start crying and it was almost whatever this was inside me had just taken me right over and just...I'm fighting this thinking am I going crazy, am I going crazy. I guess maybe the feeling I had was just basically loss of control. - Tammy

Megan and Andie also experienced headaches, while both they, as well as Sasha and Mary, found their eating increased. Tammy and Tina found, however, that their appetites decreased. Tammy, Tina, and Sasha also found themselves experiencing panic attacks. In addition, all six of the women found that they were not making eye contact with people, walked more slowly, and that their shoulders were "slumped down."

All six women found that when they were depressed, they were unable to function at home or at work. They had no energy, and spent most of their time laying down. Sasha summed it up with "the housework piles up and you can notice all the dog kibble on the floor cause it's too much for me." Mary says that she does not cook or clean house and that "if the health board were to come to my house, they would probably, literally, condemn my apartment." The effort to do daily household chores was extremely difficult for all the women. In addition, Tina, Sasha, Mary, and Andie all took time off work. They found at work they were unable to concentrate, felt overwhelmed by the amount of work they were supposed to complete, and were either ready to burst into tears or yell at somebody. Megan continued to work, but found that she was "frequently making mistakes..."
and had to have all my work checked before it went out."

These physical and cognitive symptoms reinforced for the women that they were no longer in control of themselves and were unable to perform their daily work. They felt more and more incompetent and could no longer keep up the pretence that nothing was wrong. They dragged themselves through the days, feeling that "things were going to come crashing down at any moment" and that they would be "locked away." These feelings and physical symptoms were very frightening for the women as they thought that "they were losing it and would never come back."

Going crazy sums up how the women felt about what they were experiencing. They felt they had lost control of their lives and themselves. They did not know how to identify what was wrong, or explain what was happening to them. They knew they were in pain, that they could not cope or function in their daily lives, and that they were "losing it." It was a frightening experience for all the women, and they are all scared of it happening again. They constantly monitor themselves and their feelings because "I never, ever want to feel like that again. I will make sure I get help right away if I start to feel like that again."

Cut-Off and Alienated

The second category, cut-off and alienated, resulted from all six women discussing the changes the depression had made in their lives. They talked about how the depression affected their relationships, suicide attempts, and wearing masks as a way of hiding themselves. The women felt cut-off from themselves and alienated from others including themselves.
Relationships. Tina's response to her husband and daughter was "Now leave me alone, just go about your business, just leave me in my own little world by myself." This was fairly typical of all the four women with families. Megan would "shut myself away in my room with headaches so I didn't have to deal with them." Andie liked it when "my family is all out and I can be alone. They try to be supportive, but don't really understand what I'm going through, so I feel alienated." Tammy also "shut myself in my room, smoking." While the women wanted the support from their families, they felt alienated because they could not explain what was happening for them and they did not have the energy required to deal with their families. Also, because their families did not know how to respond to them, they left the women alone thereby reinforcing the feelings of alienation.

When all the women were in the depths of their depression, they felt alienated from their families and friends, withdrew, and shut themselves away. They did not know how to describe what was happening to them, felt that nobody would understand, and were scared of how people would react to them or treat them. At the same time, they did not have the energy to try to explain what they were experiencing and as the despair increased, felt numb and totally shut-off.

"It was such an effort to talk to anybody, and I really didn't want to. But I knew if I didn't reach out, I could just shut myself away forever. Also, whenever I tried to talk about it, I would just end up crying and making no sense." - Megan

Once they started to feel better, the women all tried to talk to their families and friends about how they were feeling and wanted to build more intimate relationships through sharing their experiences, but still felt that they were not understood. Tammy's
thoughts were "unless someone's been there, they really don't understand." The women with children were also concerned that their children might experience depression and watch for the symptoms in them. Tammy says "I think too through depression, I know the signs. I watch for it in my daughter. I wonder if it's adolescence or whether she's shutting herself away because of depression."

**Suicide Attempts.** Tina and Mary also both reached the point of suicide. Mary was in and out of hospital for suicide attempts and says "I don't have a medical file, I have a medical book, mainly for depression." Mary found that attempting suicide and being admitted to the hospital was a way to "take time out from her daily life." When she found that she was not coping well and that stresses were building up, Mary would make a suicide attempt. She knew that she would be admitted into the hospital and "taken care of." Mary found that this was a way for her to ask for help without having to actually tell people that she was feeling out of control and needed help. When she was in the hospital, and for a while after she was released, "people would not make demands on her" and she found it easier to cope.

Tina also found herself contemplating suicide when she was at the bottom, and for her, this was really scary. She says "But, looking back at it now, thinking I had a gun in my mouth. I was ready to kill myself. I go, Holy Shit!" This was something Tina had never expected to happen. Unlike Mary, she was not looking for help but "a way to escape from how I was feeling." It was at this point that Tina knew she had to get help because she did not want to die, but wanted to stop feeling "in so much pain and so
scared."

Megan also reached the point where she contemplated suicide. She was sitting in
the bedroom with a handful of pills, but also did not want to die. She realized she needed
help, and called a friend. The other three women had fleeting thoughts of suicide at
various times, but also did not want to die.

Suicide attempts were Mary's way of asking for help, while for Tina and Megan,
the suicidal ideation was a "wake-up call" for how out of control they were feeling.
Because the women felt so cut-off and alienated from not only others, but themselves,
they were unable to ask for help or thought, because of their need to be in control, they
should be able to handle things themselves. Suicide was the final admission that they
needed help, and also got others to react in a concrete way - either by getting them into
the hospital or into counselling.

Wearing A Mask. All six women stated that they wore a mask, so that others
would not know how they were feeling. Mary says

So then I put on that face, that mask, like I was always, always, always
happy. If anybody needed to hear anything funny, they always knew
who to come to.

They found that they became very good at putting on this mask, although they did not feel
the need to do this at home. Wearing a mask enabled them to function socially, for the
most part when they had to, although they tried to avoid going out unless they absolutely
had to. Andie says

I got really good at putting on that mask. Or at least I thought I was. If I
had to go out, I could put it on and nobody would know how I really felt.

They found that by "playing roles", they could ignore their own feelings for a period of
time. In addition, the women all felt that they could not trust their own judgements about their feelings, so sought justification and validation from others. This seemed to be because they were not able to determine what was causing their feelings, so they were never sure if what they were feeling was appropriate to the situation. Seeking validation and justification from others helped them determine if they were reacting to their own feelings or to external situations. Megan says

I never knew if I was over reacting to what was happening, or if this was really how I should feel in this situation. For example, if my boss seemed grouchy at work I never knew if I had done something wrong, if he was just having a bad day, or if I was reacting to my own feelings, so I started asking a co-worker for her interpretations. This way I could tell if it was me or not.

As the women looked back on their experiences, they were able to identify the devastating effects that the depression had wrought in their lives. All of the women stated that this was the first time they had really talked about their experiences with depression and the effects it had on their lives, and for all of them the experience was extremely emotional, evoking tears and laughter. All the women remarked later how difficult it was for them to talk about their experiences, but how helpful it was for their healing. Even though some of the women had sought help, they all stated that this was the first time that they had fully given voice to their experiences and feelings. This seemed different for them because they were able to tell their stories in the way that made sense to them, without being interrupted, or asked to explore areas that they did not want to. Being heard without being asked to do anything with the information seemed to give the women the opportunity to really explore themselves.
Searching for Meaning

The theme Searching for Meaning emerged from the women's stories of how they tried to make sense of their experiences. This involved looking at the reasons for their depression, both internally and externally, and their understanding of their lives. This gave rise to the categories lack of control, nobody understands, and who am I.

Lack of Control

The women all described growing up in households where they felt they had very little control over their lives and where they were abused and silenced. All six of the women experienced physical, emotional, and/or sexual abuse, and they all feel that the abuse contributed to issues around control. They also talked about a genetic predisposition to depression, also over which they had no control.

Childhood Messages. One of the issues that all the women discussed was learning as children that it was not safe to talk about their feelings.

I really didn't share that much. I always felt that growing up I should try and make life easier for people, and by sharing feelings, that sometimes made it harder cause they might feel responsible for changing that. So, if you don't share it, you saved people problems. If you're a listener, you're accepted far better in my family than if you're a talker, so it became very easy to be a listener. To know that you're pacifying somebody by letting them vent at you, and not showing how it affected you. - Andie

...but I know my living with alcoholics, there was that code of silence. You know, you don't talk about your feelings, you don't talk about yourself, you don't deal with anything. - Tina

In my family, we didn't talk about our feelings and I sort of, even now, have a hard time doing that. That's why this interview is hard for me because it's hard for me to express my feelings. - Tammy

I come from a, my dad is Scottish, very you don't cry, you know. You
are the type of people that it's a weakness to cry. So that part of me,
with this depression, and I want to cry and strong people don't cry. No
we're not a family that talks about things. - Sasha

This being silenced is discussed at length by Jack (1991). All the women thought that
being unable to talk about their feelings contributed to their depression. Being silenced has
also resulted in the women feeling that they cannot trust others with their feelings and
thoughts. In fact, even now they all have a difficult time talking about how they feel
because opening up to others, they feel, makes them vulnerable and open to being hurt.
This has created difficulties for the women as they sought help but were unable to trust
enough to open up.

Abuse. These messages of being silent had even more devastating effects on
Megan and Mary, who are both survivors of sexual abuse.

It's like you have this bottle inside you, and every time you stuff
something, every time something happens, you don't talk about it.
You keep it inside you, and you keep stuffing and stuffing, and
then it's like you hit this depression and the bottle just explodes. - Mary

Mary was finally able to disclose to a friend that she had been sexually, physically, and
emotionally abused by her father. Once Mary disclosed the abuse, she felt that her life was
out of her control. The police and the legal system took over and made the decisions. Her
brother still blames her for the break up of the family, and she says that "even seeing him
triggers my depression."

Megan on the other hand suppressed all memories of her abuse until she was in her
early thirties. Her brother was convicted of sexually abusing a young girl and she started
having flashbacks. She thought at this time that

I was going crazy. I didn't understand what was happening and thought
I was losing my mind. I went for help and spent the next few years going through hell recovering memories. Some of my behaviors finally made sense though. I had always been overly protective with my children and did not trust people. The whole thing really bothers me even now though. I don't know if my memories are real, I don't know what to believe. I also don't know who I can talk to or who I can trust. I don't know why I can't just shake off the depression and carry on like other people.

The controversy over false memories and repression has made Megan's decisions even more complicated, and for somebody who was taught to be silent has reinforced the message that it is not safe to talk.

Both Sasha and Tina, who have First Nations heritage from their mothers, were taught as children that they should be ashamed of this part of themselves. Sasha's father made racial slurs against Native people, and she felt that her sister, who was blonde, was favoured. Tina's father "wanted to portray our family as a non-Native family," although her mother sent her to live with her family on the reserve every summer when she was small. This created confusion for both Tina and Sasha as they felt that they had to deny part of themselves when they were growing up, and contributed to a negative self-image which in turn contributed to their depression.

Andie grew up with a father who was frequently moody and drank to deal with his feelings. When he drank, he was verbally abusive and sometimes violent, throwing things, although not physically abusive. Andie says

You just kind of stayed wherever you were in the house and held your breath until you saw what kind of a mood he was in, and if there was a smile or something nice said, or a kiss to mom, then hey, it was going to be okay, but you were still very careful not to make him mad. But it was a lot easier than when he came in mad, and when we all tried to, you know, you tripped over yourself to make him happy. So you would continually try to do things to get him out of the bad mood. It's a lot easier to shut up and let him stay in a good mood.
Andie feels that this contributed to her depression as she learned that she had no control over her environment.

All six of the women experienced physical, emotional and/or sexual abuse and they all feel the abuse contributed to issues around control.

I didn't have any control at all over my life, and I'm a person that likes to have control and make decisions...I'm still single because I don't want anybody telling me what to do. I need to be in control of my life and as soon as I feel I'm not in control..I run in the other direction. - Sasha

My parents, the way they were, they were both alcoholics. I always saw my mother out of control and I always saw my dad out of control...fights and everything. I needed to be in control. You know, and I don't want to be my parents now. I need to be in control. - Tina

In turn, all the women felt that the issues around control contributed to the depression. When they felt that they had no control over their lives or were losing control, they were unable to voice their feelings and withdrew into themselves.

Genetics. Five of the six women also felt that biological factors contributed to their depression. Megan has two sisters who have suffered from depression, so she feels part of her depression is hereditary. She suffers from migraine headaches, which are affected by serotonin levels, that also affect depression. She says that

Part of my depression, I think, is because we have a genetic predisposition to it in my family, part is because of the serotonin levels, and part is because of what I've experienced in my life.

In Tammy's family, her mother, brother, and sister all suffered from depression and there was a history of depression on both her mother's and father's sides of the family.

About her depression, Tammy says

So I figured it's, well, it's possibly hereditary. That, you know, that's just by looking at histories that, that would be a hereditary thing. ...You know,
when I look back on my family of all the people that have been suffered from depression, I personally think that there is a definite chemical imbalance in me that I will always have.

However, Tammy does not think her depression stems solely from the chemical imbalance

Yeah, not only a chemical imbalance, but yeah that too. Because, like I said the roles or the things I've had to do over the years and not being able to talk about it, would have an impact on my feelings, definitely. So there is a relation there, there is a relation there between not only the chemical imbalance or the genetic part of it, but then there's also the part of not being able to express your feelings and keeping everything inside you.

From what the women expressed, they seem to feel that they have a genetic predisposition to depression. They also feel, however, that it is not "just genetics" but also the abuse they had experienced and the messages they had internalized as children that resulted in their depression.

Nobody Understands

As the women tried to make sense of their experiences, they looked at their relationships with their family and friends. They thought that perhaps these interactions had contributed to their depression and they needed to make sense of these relationships in order to understand what was contributing to their depression. When the women felt cut-off and alienated, they talked about how their relationships were affected by their depression, but in searching for meaning, the women looked at how their relationships affected their depression.

Family Pressures. All six of the women stated that their relationships with various members of their family of origin had impacted their depression. Of her family, Sasha says
Maybe I'm expecting them to be the type of family that doesn't exist, specially in my household. We've always had problems. We've never been a really close family, but maybe I'm expecting because I need the support. I'm looking for that closeness, that family that cares...and there's a conflict there.

The myths about how families are, the ideal that is held up of a close, loving, nurturing family, seems to have effected all the women. Sasha also feels that her family puts pressure on her to keep in contact, but she does not always feel like talking to them, and that most of the contact is superficial. Her wanting to have a close, meaningful relationship with her family and the lack of that relationship contributes to her feeling depressed. She says that she sees her friends who live out of the area more than she sees her family who only live half an hour away because she does not have the relationship she wants with her family and feels they do not understand her.

Of her relationship with her family, Tina says

Yes, it wasn't until recently that my dad even said he was proud of me, maybe in the last five, six years. My dad first said I'm proud of you. I'm proud of what you've done. I'm proud of who you are. He doesn't know what I've done. He's just proud of what he can see from the outside. He doesn't know anything about what's on the inside, and he doesn't know me. It's very important to me that he see what is on the inside, but will he ever do that? I don't know.

Though being bi-sexual, Tina felt conflict hiding her relationship with a woman from her family

My mother is definitely homophobic, and my uncle is gay and she blackballed him from the family, and I always had that fear, if she knew about me, that I would be blackballed and I never came out of the closet with her because I feared that I would lose my mom.

Tina felt this conflict really contributed to her depression as she could not have an honest relationship with her mother and because she couldn't be "the person I wanted to be."
Additionally, she was concerned for her daughter who was being teased at school, which Tina says increased her depression.

The four women in the study who were married also talked about how members of their chosen family impacted their depression. They all felt that while their husbands tried to be supportive, they did not really understand what was happening and were frequently frustrated. Even though the women themselves did not understand what was happening to them, and could not explain it, they wanted their husbands to understand. While all the women made similar comments, Megan summed it up

He tries, but because he can't fix it he doesn't know what to do. He can't just listen. So, he either says the wrong thing or gets upset, which just makes me more upset and depressed. He just doesn't understand.

Regarding their children, Andie summed it up

When I'm depressed, they never know how I'm going to be, so they stay away from me and don't talk to me, and then I feel alienated, which makes me even more depressed.

These experiences were common throughout all the women with families, and the women felt even more stress dealing with their husbands and children, which increased their depressed feelings.

Exploring their relationships with their family enabled the women to make sense of some of their experiences, and how some of these relationships contributed to their depression. They were able to decide which relationships they wanted to work on and how they would like these relationships to be. For some of the women, this meant accepting that their relationships with their family of origin were not going to change, while for others they decided that they wanted to try to connect with various family
members. Tammy decided to talk to her mother about "her depression and what her life has been like" to try to build a more meaningful relationship. Sasha decided to "accept that my family isn't going to change, and this is the only relationship I'll have with them."

**Experiences With Friends.** The women also had mixed experiences with friends. All six of the women thought that their friends would comment if they saw something was wrong. Andie summed it up:

> I thought if people would have cared, they would know something's the matter, and why didn't somebody make comments to justify you being worried about yourself; because I figured if nobody could see, could notice or, nobody made a point of saying what's going on, then maybe it wasn't. Maybe I was just imagining it that something's going on inside. I think a lot of my issues in my life are with that, that I always knew something was wrong and I kept waiting for somebody to realize it and help me fix it, so that if somebody else recognized something wrong in my life that made it justifiable.

However, the women all shut their friends out and pretended that things were alright. When they were approached by a friend, they did not open up because they felt they would be misunderstood. They were scared that they would be hurt or that their friends would think they were crazy.

The women all commented about how they were silenced as children and how they found it exceptionally difficult to open up enough to make really close friends to confide in. Sasha said:

> I mean, I'm the type of person that, I am friendly but it takes a lot. I am also very shy. It takes a long time for me to find a close friend that I can confide in. Both my best friends had recently moved out of the lower mainland, so I didn't have a real strong support system, and my family wasn't there for me.

All six women found it hard to talk to most of their friends about what they were going
through. Part of this seemed to be due to the way they had learned to silence their feelings and part seemed to be due to feeling that their friends would not understand and think they should just "get over it."

Looking at their relationships with friends enabled to women to make sense of some of their actions. It gave them the opportunity to look at issues of trust and what kept them from opening up. Without understanding these issues, they felt that they would not be able to make changes that would help them from becoming depressed in the future.

Who Am I

The category who am I describes the women's experiences with trying to integrate themselves into what others expected them to be. They talked about the need to be the perfect woman in a variety of roles, and how society's expectations of what it means to be a woman impacted their depression. The women all talked about how society expects women to be self-sacrificing, always nurturing and putting others needs first, and able to juggle being the career woman, wife, and mother.

The Perfect Woman. The women all felt that they were expected to be perfect as women, and although some of them rebelled against this they felt unable to get away from being pressured into this ideal. The various roles the women in the study had been expected to play in their lives, they felt, had contributed to their depression. In fact, Tina did not even want to be a girl when she was growing up. She took mechanics and other 'male oriented' classes in school and felt that "somehow being a boy was easier, it was better. I didn't have to worry about the emotional stuff." She felt that it was the female who was supposed to be the emotional one, while males could be action oriented.
However, this refusal to take on "traditional women's roles" caused conflict for her as she did not feel accepted in either the "men's world or women's world." In the end, she felt obliged to try to become the perfect woman, which led to feelings of depression as she felt she did not measure up and no matter what she did, she never would.

Tammy says that she has had many roles "mother, student, wife, doctor, nurse and jees there's a variety of things you take on as a woman." She feels that taking on all these roles is very stressful, and that "what it comes down to is do I really have time for myself?" In addition to taking on all these roles, Tammy's husband worked out of town frequently when their children were growing up. Because of this, she felt that she had to be both mother and father to their children, that she had no support, and that she never got a break from being totally responsible. The isolation and the stress combined with feeling that she "had to do it right" led to her feeling depressed.

Of women's roles, Sasha says

I mean, you have a single mom, and she has three kids, and she's trying to make ends meet, and she's only making eight dollars an hour cause she's got office skills only, and unemployment's really high so she can't get another job, so she gets depressed. Even if a woman is married, she's the one that's responsible for co-ordinating everything, for making sure everything's running smoothly and everyone else's needs are met. It's no wonder women get depressed, they have to take care of everybody and do all these things with little or no support, and nobody's taking care of them, and they don't have the time or energy to do it themselves.

Sasha was not talking solely about her own experiences, but also about experiences of other women she has known. She feels that women are constantly trying to attain an ideal that is impossible, with few supports, resulting in depression.

The women summed up how they felt about the roles that they had to be the
perfect wife, the perfect mother, the perfect worker, perform all their roles perfectly and that this stress leads to depression. The conflict is between who they are as individuals and how they are expected to be as women. Once they realized this, they were able to work to let go of the idea that they had to be the perfect woman.

**Society's Expectations.** The women all felt that how society expects women to be impacted their depression. Much of the conflict between who they are and who they think they should be comes from the messages that women receive from the community. Sasha says that

> We're getting the message to girls and women to get out there and get an education, but what are they supposed to do with it, and just because you get a university degree doesn't mean you're going to get more money. At least I make the same amount as the men, but in terms of promotion into upper management, forget it. There's a very small percentage and we tell these girls to go to school, but then they still can't get the promotions or opportunities. It's no wonder women get depressed.

These double messages leave women "confused, angry, and sad, and their goals and expectations are frequently unobtainable given the current structure of many institutions." Because "we are told that we can reach these goals, when we fail it's because of something we did or didn't do." Women then see it as a personal failure and deficit, rather than as a problem with the way society is structured. Personalizing and individualizing their problems increases the chance that women may become depressed.

Additionally, Tina found that messages from the community about bi-sexuality impacted her depression. She felt that she could not be herself, and that she was split all the time.

I couldn't be myself, it was hard, really hard, even working. There
were only one or two people who knew I was with a woman. I never said anything, but you knew that they knew. Even other workers at work, you can't say that to. There's the fear of retaliation, someone that's bi-sexual working with us, and the taboo and that was really hard. So there was fear, and I think that part of it was too, what's wrong with me, why am I like this. And you start really looking at yourself and going, I'm really fucked up. All those self-doubts kicked right in.

She still runs into people who think that homosexuality is a mental illness, and many people also consider depression a mental illness and stigmatize people who suffer from depression. All six women discussed this stigma and how this prevents them from talking to people about their feelings and experiences. Tammy thinks that "people would think I was crazy" and Andie says that "before I recognized that I was depressed, I always thought that people who were depressed were mentally ill, and that you could see that there was something wrong with them." Mary summed it up

There's no cure to it. I think that society needs to realize that it's not an evil thing to be depressed, that you need to get rid of the social stigma. That there's something wrong mentally with everybody who's depressed, and that if they're depressed, there's a reason they're depressed, so let's figure out what.

The women in the study also talked about how the media portrays women, how that impacts women's self-images, and how that can lead to depression. Mary talked about how "I didn't look like the girls on TV. I was fat and had to wear 'old lady' clothes because they don't make trendy clothes in my size, and it's depressing." Tina's, Tammy's, and Megan's comments on the media portrayal of women express all six women's thoughts on the subject.

I think that from society as a whole, you know, through TV, through magazines, what they're printing about women, the perfect body, the perfect hairstyle, the perfect clothes. You know, I could bet dollars to
donuts that my daughter alone, seventeen years old, is depressed because she doesn't live up to that stereotypical image of women. It's everywhere. So all those images of what a woman is, who a woman should be, and when you don't fit into that criteria, it's depressing. - Tina

You know the way they portray women in men's magazines, that they're sexy and provocative, their not people, just objects. It causes rape and abuse, well I'm not saying it causes it, but it instills different things in the guys than it does in the girls. Women are objects, and that's how I've felt at times. - Tammy

All my life I've tried to be what everyone thought I should be. I dieted, I exercised, not that you'd know it now. I tired to look like the models. When I was young, I don't even think guys saw my face, just my body. Lots of the time, I didn't even feel like a person. - Andie

It seems that the women in this study were all affected by these messages because all their lives they had been trying to live up to someone else's expectations of who they should be. It is no wonder that when women who have been striving all their lives to be someone they are not, they internalize the messages that they are objects. They feel they can never live up to the women who are held up as the ideal and they become depressed.

The women's search for meaning, although written as though one subject lead to another, did not emerge in that manner. The process of looking at what was important to them and what held meaning was a painstaking and arduous journey for all the women. At this point, four of the women are still trying to make sense of their lives and their experiences. The other two women are comfortable with how they have made sense of their experiences. They feel that the roots of their depression lie in the abuse they experienced as children and how the way they saw themselves and related to the world followed them into adulthood. They feel they understand what caused them to feel depressed, what changes they need to make in their relationships, and feel that they are at
a point in their lives where they are able to look ahead.

**Regaining The Self**

The theme *regaining the self* emerged from the women's discussions around moving beyond depression. The women talked about who was helpful to them, the use of medication, how they could help themselves, the importance of education and women supports, and free, accessible counselling. This gave rise to the categories *opening up*, *finding that balance*, and *making changes*.

**Opening Up**

The category *opening up* discusses whom the women were able to talk to and the importance of having a friend they trusted and the role of professionals.

**One Accepting Friend.** Although all the women had discussed how they were unable to talk to most of their friends, they all identified one close friend that they could open up to. Sasha's two closest female friends had moved out of the area and she found that she lost most of her support system when this happened. She could not afford the long distance telephone calls, so instead started talking to a male friend who became her confidant and support system. Without him, she says, she would have "gone crazy as there was no one else to talk to."

Mary also had a male friend that she turned to. She "didn't feel judged by him and he didn't try to get into my head the way females try to." She felt that she could share as much with him as she felt comfortable, and that he would not push her for more. She felt that females always wanted to analyze everything she said, and dig for more information. One important factor that she identified was that "he had also had a messed up life, so he
understood."

The idea that only people who had experienced depression understood what they were feeling and going through was voiced by all the women.

When somebody's suffering from depression, I think people who haven't been through it don't understand it, cannot relate to it so they cannot really, well they will be supportive but they have a difficult time. They think like what is their problem, so there's frustration there. - Tammy

Because of this, the women felt that friends who had experienced depression were more supportive and understanding. All of the women identified at least one other woman in their lives who had experienced depression and they named this person as providing the most support. While the women all identified having a friend to talk to for support, there was also the reluctance to talk stemming from their silencing their feelings and the reluctance to let go of the mask. Tina summed this up

Well, there's always people to talk to, the point is are you willing to talk to them. Are you willing to put yourself on the line. Are you willing to open yourself up. I think it doesn't matter how many friends you have around you, it's what you're willing to do, you know. What you're willing to do. How willing are you to open yourself up and to acknowledge that you're depressed, you're having a hard time?

While the women recognized that friends were a source of support, all six women found it difficult to open up and express their feelings. It was not until a friend approached them with concerns about the changes they saw that the women actually talked about what was happening to them. In all six cases, the person who approached the women was accepting, did not judge them or stigmatize them, and understood about depression.

These findings indicate that the depression process is circular. The women feel depressed and start to withdraw. They find it difficult to express their feelings, and unless
someone else approaches them with concerns about the changes they are witnessing, they do not talk about their depression. By not talking about it, they feel more isolated and their depression increases. There is also the fear that they will be stigmatized and misunderstood if they do try to talk.

**Professional Supports.** All of the women also talked about various professional support systems, which for the most part they found lacking. Tammy's doctor sent her to a psychiatrist who prescribed antidepressants, but when she went back for her second appointment he called her by the wrong name and had somebody else's file out. She did not go back and feels that "professionals are not going to help." Megan also saw a psychiatrist who fell asleep on her and she did not return. She had a better experience with a support group for women survivors of sexual abuse, but found that it did not help her depression and in many ways increased it. As she explored her memories, she became more depressed and "crazy," and this was not addressed by the group.

Sasha and Tina both saw therapists who were not psychiatrists. Over the years, Sasha has seen three different therapists with varying degrees of success. One psychologist was "a male from the old school and his attitude was just do what they want and everything will be fine, and that was the last time I saw him." Another therapist worked through "reaching the inner child and that's not a perspective I believe in...so I stopped going after the third visit." She finally found a psychologist who worked from a cognitive perspective, which worked well for her, but unfortunately he left to continue his education. Her concerns around professional supports are that:

- It may take a few visits to determine if the perspective the therapist uses is an approach that works for the client, that it often takes too long to
start any meaningful work, and that when women are depressed they do not have the energy to research therapeutic approaches and assume that the professional knows the answers.

Tina's doctor referred her to a feminist therapist, and she found this woman incredibly helpful as she normalized Tina's feelings and experiences. Tina was the only woman who had a totally positive experience in therapy. Sasha finally found a helpful therapist, while Tammy and Megan never did.

Because Mary has been seeing various counsellors since she was a child, she has had a variety of experiences. She was sent to two male psychiatrists, which did not work for her as she did not trust males and would not open up to them. She also saw therapists at Mental Health, but as soon as she started to feel a little better "they said I was fine and didn't need to come anymore." She found this really frustrating as "you have one good day and you're fine. No." She has been in and out of hospitals for suicidal thoughts and suicide attempts, mostly when she was younger. She now uses the hospital for support when she starts to feel that she "can't handle the depression." She has found the hospital day program to be the most helpful

In the mornings we work on assertiveness and anger management (to her, assertiveness is being able to stand up for herself and managing her anger is not turning it on herself or losing control with others) and stress management, and then in the afternoons, there's all different groups that teach us leisure skills, like it's okay to unwind and do something that you want to do. There's a wellness where they teach the affirmations which, that's the one I'm having problems with is the self-affirmations. It doesn't work. It doesn't work just yet.

Mary is still trying to integrate the skills she has learned through counselling and she has "finally learned that I need to do this for me."
All six women saw their doctors as part of their support system. Andie’s doctor has prescribed antidepressant medication and suggested counselling referrals, which Andie has refused. Instead, she talks to her doctor about some of her family issues and because he knows her family, she finds his viewpoints helpful. Tammy’s doctor has also prescribed antidepressants and referred her to a psychiatrist, but since her experience was not good has not referred her to anyone else. Tina’s doctor did not prescribe medication but referred her to a feminist counsellor and also for massage therapy, which Tina found wonderful for reducing tension. Megan’s doctor also prescribes medication, and since her bad experience with the psychiatrist Megan has not been interested in any other referrals. Megan’s doctor spends time talking to her about the various stresses in her life and makes some suggestions about alternate actions. Megan trusts her doctor and finds him very helpful. Mary has had a lengthy relationship with her doctor, which she finds conducive to her mental health as she does not have to continually explain her history and go through which medications have worked and which ones have not.

From the discussion around professional supports, all the women identified their family doctors as being their primary professional support. Only Tina had a positive experience with therapy and all the other women were reluctant to seek additional counselling after their experiences. While their experiences with professionals was not entirely positive for the women, what they identified as being helpful was trying to open up to other people. For the women, learning to talk about their feelings was an important step in their recovery.

Although, as mentioned before, most of the women’s experiences with therapy
were less than satisfactory, they could all see value in counselling. Sasha summed it up

Drugs don't cure the depression, they just mask the symptoms and it makes you feel better, but being on drugs then you're in a drugged state all the time. So you replace sadness with maybe some energy, but you still haven't dealt with what caused the depression, so once you get off the medication then you get right back to where you were unless you've dealt with what's causing it.

Sasha found that cognitive therapy worked best for her, and the literature supports that cognitive therapy is the most beneficial for changing negative thinking patterns. Tina found that talking to people who were not involved in her life was really helpful as they could normalize her experiences and feelings.

However, most of the women were reluctant to pursue counselling, in part, because of their prior experiences. Additional factors, such being silenced as children, a lack of trust, not wanting to explore painful feelings, not understanding the counselling process, and not knowing what approach the therapist was using also came into play with the women's reluctance to enter into counselling.

**Finding A Balance**

The category finding a balance describes the women's dilemmas with finding, and accepting the right way for them to heal and regain themselves. The issue around medication evoked a variety of feelings for the women. All six of the women felt it was a weakness to take medication, that somehow they should be able to control their feelings and cope without having to take pills every day. One of their main concerns was the stigma they felt was attached to being depressed and on antidepressant medication. Their other struggle was with how they could help themselves and get what they needed.

**Medication.** One issue that evoked a variety of emotions in the women was the
issue of medication. One of the main concerns for the women was the controversy over the medication Prozac, and the stigma they felt was attached to it. Megan does not tell many people that she is on Prozac because "even people at work make derogatory comments about Prozac. They make jokes about people who have to take it." Only her husband, sisters and closest friends know that she takes it. She has not told her children as she does not "want to deal with trying to explain it to them." Since she has been on Prozac, she has tried twice to go off it. Both times she stopped taking it, she became severely depressed again. When she is on the Prozac, she can deal with her work, her family, and various community commitments. She has energy and she feels happy with her life. It bothers her that she has to take medication every day to cope, but not taking it is "worse."

Andie's experiences with medication is similar to Megan's. Andie has been on antidepressants twice now, and trusts that her doctor cares about her and is not a pill pusher. Andie puts a lot of faith into her doctor as the expert. However, Andie is not comfortable taking medication as she feels others judge her and think that she must be weak if she has to take medication to control her emotions. She feels there is a stigma attached to being depressed and on medication, and that a person taking medication is thought of as mentally ill. Andie thinks that she should be able to control her feelings but, after becoming severely depressed again when she stopped the medication the first time, realizes that she is not able to control the depression without medication. This bothers her, but like Megan, she would rather take the pills than be unable to function because of the depression.
Tammy has tried Prozac twice. The first time, she only took it for a couple of weeks. She says she "threw it out because there was so much negative press about it and I thought I could deal with this on my own." The second time, she was on it for almost a year and also took antianxiety medication for panic attacks. This time, she stayed on the medication long enough for it to work and says that "if I ever get depressed like that again, I will do something sooner. I will go and get the pills sooner." Like Megan and Andie, Tammy does not like the idea of taking medication but realizes it's value. She does not think that she will have to be on medication for the rest of her life but thinks that "if I get depressed again I will take the pills until I feel okay and maybe this is a cycle I'll go through every so often."

Mary's experiences have been somewhat different. She has tried different antidepressants and sleeping pills, but they have all had negative side effects that she says "brings on another depression because anything the professionals do doesn't work anyway." She is currently taking antianxiety medication that she says seems to be working for her. She says the idea of taking medication does not bother her. She just wishes that "I could take something that would work without any side effects."

Sasha's experiences have been more like Mary's. She has tried a variety of medications but they have all had negative side effects so she has not found anything that works for her. She has refused to try Prozac because of the negative connotations and because she thought "no way. I'm not that bad. I don't need it," buying into the idea that only people who are "really crazy need Prozac." Sasha does not like "filling my body full of drugs," so she has tried natural remedies like St. John's Wort and meditation. At times
these natural remedies have worked better than at others. However, she would prefer to keep trying them than to keep trying medication.

Tina has never been on antidepressants and like Sasha does not agree with taking medication. She realizes that there is value in it for some people, but thinks that she now knows what she needs to do to help herself. She does admit that if nothing else was working, she would take medication "if I absolutely had to."

All six of the women felt it was a weakness to take medication, that somehow they should be able to control their feelings and cope without having to take pills every day. This created great inner conflict for them, and they all had to find ways to justify and rationalize their choices. Tina was even concerned that by making negative comments about medication, she was criticizing women who took them, which was not her intent as she can see value in it. The women were concerned with the stigma attached to taking medication, especially Prozac, and felt uncomfortable having to take a pill every day just to cope with life. However, the women who were taking medication that worked for them found that they had the energy to start dealing with the causes and effects of their depression. They felt that they were once again able to lead their lives the way they wanted to.

**Self-Help**

The other process the women thought assisted them with healing from depression was self-help. To the women, this meant the things that they needed to do and be aware of to help themselves. Tina summed this up with

I think the biggest thing is that it's not permanent, it's not going to last. I think it's a point where it's part of your life that is lacking somewhere
that puts you in this state. You need to find out what is happening that is making you like this. It's not that you're not a worthwhile person, it's not that you're garbage or useless. It's a temporary state and as soon as you find that balance, as soon as you can identify where you're unbalanced then you can change that.

At work, Tina came up with a self-help plan identifying her signs and symptoms so that her co-workers would be able to point out to her if they saw her becoming depressed. She works in the social work field, and says that many of her co-workers are experiencing stress with their jobs. They spend time talking about how to take care of themselves, so she also had her co-workers fill out their own plans. She says that this has made the environment at work more supportive. She found this has worked really well as she does not have to keep doubting her own interpretation of events and can ask others for input.

Some of the other self-help techniques that the women found worked for them were taking time off work if they felt they needed to, going for walks, taking bubble baths with soft music and candles, utilizing meditation and relaxation techniques, and exercise. The biggest help, they said, was giving themselves permission to take time for themselves without feeling guilty about it. They realized that if they did not take the time and do what they needed to do to feel better, no one else was going to do it for them and they could not take care of anyone or anything else until they felt better themselves.

Finding a balance was a difficult process for all the women as they struggled with the stigma they felt was attached to being depressed or on antidepressant medication. The women who decided to take medication felt uncomfortable taking it, and that they had to rationalize and justify their choices. They did this through deciding that the medication was necessary for a chemical imbalance. One of the biggest realizations for all the women
in finding a balance was that it was necessary for them to take care of themselves and that they did not have to feel guilty about it. Finding a balance seems to be about finding out where "I" am in the equation.

Making Changes

The final category, making changes, looks at the areas where the women thought changes should be made. They were concerned with the stigma they felt was attached to being depressed, which they felt continued to silence women. They were also concerned with what they saw to be a lack of appropriate support and counselling.

Education. What the women want is for depression to be normalized rather than stigmatized. They felt that this could be accomplished by educating people about the reality of women's lives and that "depression is often a natural response to what women are dealing with on a daily basis and is not a mental illness."

Because all the women stated that they had never learned how to give voice to their feelings, they thought it was important for young girls to be taught how to do this. They felt that schools should take on this role as most of the silencing is learned at home and then reinforced in the community. By including modules on communication and active listening in the general curriculum, all children could benefit from learning to express their feelings and listening to others with empathy. The women felt that girls need to be taught how to use their voices and how to take care of themselves rather than just being taught how to take care of others. They want education on depression, the signs and symptoms, and how to deal with depression, and they want women's issues taught in schools so that females experiences are validated and normalized. Megan says
We've come a long way with research on depression, but we've still got a long way to go. We have to look at the way girls are socialized. We have to talk about the reality of women's lives and what they are faced with every day. We've been through being property, being subservient, being the superwoman able to do it all, and now we have to find a balance and be happy with who we are.

**Women Supports.** Another recommendation from the women addresses the importance of female counsellors. The women all felt that their depression stemmed from the fact that they were female, and felt most comfortable sharing their feelings and experiences with other women. They felt women could identify more with each others experiences. Tina summed it up:

I would kind of expect a man not to understand what I'm feeling. There are some men who can listen, but I think for a woman it needs to be another woman to understand what they're feeling. It's just my experiences with male counsellors, my experiences with my male co-workers, how they deal with other women I just shake my head. It's not a sexist comment. Like I said, there can be some men out there who can be very, very good, but I think when it's just women alone, empathy and all that, I don't think you can get that with a man.

The women in this study wanted female counsellors who were clear, from the beginning, what the counselling process would be; who were open to working collaboratively and did not act as the experts; and who had either been depressed themselves or had a really good understanding of women's experiences with depression. This finding reinforced the need for feminist counsellors, rather than psychiatrists working from a male centred therapeutic approach, for work with depressed women. The women also thought that support groups, lead by women who had experienced depression would be incredibly beneficial, not as a "bitch session" but as a way to share experiences and help and support each other in an empathetic, safe environment.
Free, Accessible Counselling. The only free counselling that was available to all the women was through Mental Health or from psychiatrists. The women felt stigmatized utilizing there services, and found that what was provided often did not meet their needs as the services were not woman centred or collaborative in their approach. In addition, the wait lists for Mental Health services were lengthy and the women often found they did not qualify if they were not suicidal, or presenting with a mental health crisis. Some of the women were also concerned about utilizing Mental Health services as they work in the social service field and were afraid that their reputations would suffer if people found out they were seeing someone at Mental Health.

Mary, who qualified for counselling through Worker's Compensation also indicated problems such as having to find her own counsellor and set up the services, which she found overwhelming when she was depressed. Some of the other women had extended health benefits that paid for some counselling, but many of the women's employers did not offer extended benefits. For the women who had extended health benefits, they still did not have a choice of counsellors or know what approaches the counsellors worked from. The women complained that they often did not know what was available, and they did not have the energy to research available services and the approach used.

The women all stressed the need for free counselling, as many of them could not afford to pay for it, and they were not happy seeing psychiatrists or going to Mental Health. What the women recommended was a list, available at the doctor's offices, giving the background of each counsellor, the approaches they used, and their areas of expertise.
They wanted the government to cover the costs, or for the counsellors to provide a sliding fee scale that was realistic with what the women could afford.

About moving beyond depression, one of the women said:

The hardest thing about depression is you take off the rose colored glasses and see things the way they really are, and the hardest thing of all is putting them back on.

Summary

While the women's experiences are described in a linear fashion, there was a constant flow between one area and another as the women tried to make sense of what was happening for them. Although all the women's experiences were very individualized, there were commonalities between them. All the women learned as children that it was not safe to talk about their feelings, ideas, or thoughts, and have carried this with them into adulthood. Consequently, they have problems opening up to others. It is generally thought that women seek help and talk about their feelings, yet all these women had great difficulty in these areas. They were able to talk in general, but when anything came too close to how they were feeling, they would "shut down." This has ramifications for working with women experiencing depression as time would have to be spent building trust and seeking clarification of underlying meanings.

Women are generally socialized into expressing feelings that are considered feminine. As girls, they receive messages that it is acceptable for them to cry; that they are the weak ones while boys are the strong, non-emotional ones. They learn that they should be gracious where boys can be aggressive. From the women's stories, it seems that they experienced extreme socialization where they were not allowed to express any "negative"
feelings such as sadness, anger, frustration, guilt etc. This "stuffing" of feelings and silencing, the women agree, have contributed to their depression. They think that learning to effectively express feelings as children would help combat depression in later life. From this it seems that how boys and girls are socialized into expressing feelings needs to be reviewed, as does teaching children that all feelings are "acceptable." Perhaps male "negative" feelings are expressed as aggression while female's are expressed as depression.

The areas of experiences that were common to all these women could provide a base to be explored further with other women experiencing depression in order to provide information on areas where services could be concentrated to assist women experiencing depression or to hopefully minimize the number or women who become depressed. Chapter Five concludes the thesis with a discussion of how the results of this study correspond with the literature review, and the implications for social workers, helping professionals from other disciplines, and others involved in program and policy development for women.
The intent of this study was to conceptualize women's experiences with depression. The results indicate that while each woman's experience is unique, there are commonalities between the women's stories. Although the data obtained in these six interviews has been rich in explicating how the women make sense of their experience with depression, the results must be considered cautiously due to a variety of reasons. The sample size was small, the women all lived in the same area of the country, had all been raised in the same culture, and were all from the low to middle class. In addition, I had experienced depression, and while having the women participate in the analysis to ensure accuracy, I may have slanted the analysis in light of their own experiences. According to Glaser & Straus (1967), however, the generality of concepts depicted by these women's experiences may be applied to a wide variety of situations where similar histories exist.

A possible controversial point in this study could arise from the fact that I have been depressed and have ideas about how to make sense of the experience of depression based on my own personal experiences. Hence, it could be argued that I come to this research project with preconceived ideas influencing the nature of the questions and the outcome of the research. However, feminist research often utilizes the strengths inherent in personal experience. Personal experience is seen as relevant, and repairs the pseudo-objectivity of a project (Reinharz, 1992). Feminist researchers may also explicitly study a phenomena that concerns them in their personal life, thereby merging the "public" and the
"private". Starting from one's own experience is a way the researcher can assure herself that she is starting from the standpoint of women (Reinharz, 1992). Another researcher looking at the same data could have derived different themes and categories, based on valuing the statements in alternate ways than I have. I used my own experiences as a basis for what I thought women's experiences with depression might be about. My experiences with depression were similar to the experiences all the women talked about. I had grown up in a physically abusive home where feelings were not talked about. I felt I should always be in control. I also did not recognize that I was depressed, although because of my job I had information on depression and knew what to do to help myself. Unlike some of the other women, I knew that these feelings were not permanent and that antidepressant medication could help me get to the point where I had the energy to start dealing with the issues that led to my depression.

I believe that one of the most important aspects of exploring what has previously been hidden or ignored is to generate dialogue and increase understanding. In this study, I wanted to engage with the women in order to co-create knowledge. Through conducting follow-up interviews to verify my interpretations of their experiences and inviting the women to participate in the data analysis, ownership of this study is shared and the women's stories are honored. Participatory research is most effective in emancipating participants when researchers self-disclose, multiple interviews are conducted and there is negotiation of the interpretations. Research designs can change people by encouraging self-reflection and facilitating a deeper understanding of their situations in the world (Lather, 1988).
A larger sample population, with women from a variety of backgrounds such as different cultures, socio-economic status, sexual orientation, and areas of residence would perhaps have provided more depth to the study. However, these results may be generalized as according to Kvale (1996) naturalistic generalizations are derived from personal knowledge of "how things are and leads to expectations rather than formal predictions; it may become verbalized, thus passing from tacit knowledge to explicit propositional knowledge." (p.232). Additionally, analytical generalizations involve "a reasoned judgement about the extent to which the findings from one study can be used as a guide to what might occur in another situation." (Kvale, 1996, p.233). While the preliminary findings in this study require further investigation, the present results certainly indicate several implications helping professionals could consider when working with depressed women.

To date, the majority of research on depression has been done quantitatively and it is based on this research that policies and programs affecting depressed women have been formulated. The actual stories or the women, their lives, experiences, hopes and wants have been ignored for the most part. This has limited our understanding of what needs to be done to combat depression in women.

The women talked about the devastating effects that depression wrought in their lives, and the theme, Losing The Self, encapsulates the idea that the women were so far removed from their feelings, "shut down and deadened," that they had lost the essence of who they were. They had withdrawn, not only from others, but also themselves because they could not stand the pain they were feeling. While the feelings and physical symptoms
the women experienced have been detailed in the literature, what has been missing is the
twomen's lived experiences. These experiences emerged in the category going crazy. The
women talked about what the experiences meant to them, and how they were affected by
them. This provided insight into the internal workings of depression, rather than just a
clinical list of feelings and symptoms.

The results that emerged were that the women were unable to identify that what
they were experiencing was depression. If information were available on the experience,
perhaps more women would be able to recognize and identify that they were depressed,
thereby seeking help earlier. The information could also assist those who are close to
women going through this experience understand the experience more, and enable them to
help name the experience as depression. While some of the women had a difficult time
accepting the diagnosis of depression because of it being classified as a mental illness,
once it was labelled, they were able to realize that they would not feel like this forever,
and that help was available. This indicates the need for information of women's
experiences to 'normalize' them. While the experience of depression is devastating,
viewing this experience as typical of depression would help to eliminate the idea that it is
individual women who have problems. There are systems set up that produce depression
in women, and these results indicate the need to review the classification of a major
depressive episode as a mental illness.

The findings that emerged from the category cut-off and alienated concur with
much of the self-in-relation theory of depression, seeing social intimacy as the central
organizer of women's experiences. It views the development of depression as tied to the
establishment and maintenance of close relationships (Jack, 1991; Thompson, 1995). All six women wanted close relationships, yet found it difficult to trust others because of the silencing they had learned as children. The women all seemed to hold back in most of their relationships because they feared being hurt if they really opened up, and all of the women talked about wearing a mask so that people would not really know how they were feeling. At the same time, they wanted support and understanding from the people they felt close too. This inner conflict between needing to feel safe and needing to have intimate relationships seems to have impacted their depression to the point of suicide for three of the women. From this result, it seems that there is a need for additional research on how women shape their identity in relation to others and how they can get their needs met within their relationships. It also has ramifications for anyone working with women experiencing depression as time would need to be spent clarifying the underlying meanings and feelings, which can only be done through a trusting relationship.

It seems that, in general, the women's stories support Gilligan's (1982) assertion that women question the normalcy of their feelings, and alter their judgements in deference to other's opinions. While all the women's depression stemmed from their experiences as children, it seems that what they lost was their voice and their ability to trust their feelings and judgements. From these results, research on women's developmental process needs to be done to validate women's experiences and ensure that treatments based on these theories are designed for women. It is not women, individually, who do not fit into the traditional developmental theories, but rather that the theories have been based on male experience.
Lack of control was a major issue for the women, and came through clearly in the theme Searching for Meaning. The roots of the women's depression lie in their childhood where they experienced physical, emotional, or sexual abuse, and they grew up in environments where they had little control over their lives. Additionally, the messages they received as children reinforced the idea that they should not talk or open up to others. These experiences seem to have been internalized as "keep quiet and keep safe."

This finding supports Seligman's (1975) theory of learned helplessness which asserts that when people are denied the opportunity to control their environment in their early years, they learn that their actions have no effect on the consequences (Corob, 1987; Narine & Smith, 1984). Because it was the abuse that resulted in the women losing their voice, it seems that they had learned to be helpless because of the trauma. The lack of control, along with being unable to talk about their feelings, seems to have set the stage for depression in these women. It may be that depression is a natural response to abuse and trauma. Further research in this area could contribute to the theory of learned helplessness and women's experiences, and would enable programs for abused women to include understanding of and treatment for depression.

One of the results that emerged from the category lack of control, is consistent with the genetic theory of explaining depression. This theory states that depression is linked to the chromosomes that determine gender as families with an immediate member suffering from depression are two to five times more likely to suffer from depression (Fromanek, 1987; Nolen-Hoeksema, 1990), and some of the women identified family members who had also experienced depression. One sub-category that emerged was that
these women all believe that they have a genetic predisposition to depression, although they also believe that this is only one of the reasons for their depression. All six women identified that they had experienced physical, sexual, or emotional abuse while growing up. It is reasonable to assume, from the women's stories, that the abuse and silencing they experienced have also affected other family members which may account for what seems like a genetic predisposition to depression. Further research into depression, abuse, and family members' experiences could uncover the links between these two areas and perhaps explain what seems to be family genetic predispositions to depression.

Two other categories, nobody understands and who am I also emerged from the search for meaning. In nobody understands, the women talked about how their relationships with family and friends was affected by their depression. All the women felt their relationships with their families of origin were superficial. They wanted close relationships, but felt that their families did not understand them, or really want to at times. They also thought that their friends would comment if they saw that something was the matter, but this was not generally the case. The women all talked about hiding behind masks, but somehow thought that their friends would see beyond this. When this did not happen, they minimized their own feelings and questioned the validity of how they though they were feeling. Looking at these experiences enabled the women to look at their issues around trust, and what they finally realized was that nobody understood because the women did not trust enough to really open up about what they were feeling and thinking.

These results indicate, once again, the importance of taking time, building a trusting relationship, and seeking the underlying meaning when working with women
experiencing depression. How women with depression could present or talk about themselves may not be an accurate depiction of what is really happening for them, and they may be searching for someone to identify the underlying feelings. If their statements are taken at 'face value', the women could continue to minimize or try to deny what they actually feel, leading back once again into the going crazy stage.

The other areas the women looked at under the category who am I, were who they thought they were supposed to be as women and what society expected of them. The women felt pressure to conform to the way women are portrayed in society, yet this frequently created inner turmoil and doubt as they struggled with who they thought they should be and who they were. They felt overloaded with all the various roles they had, and that they got lost as individuals. Constantly striving to meet others' needs and being whom others wanted them to be created feelings of inadequacy. This indicates the importance of teaching girls and women to value themselves for who they are, and the need to take time to have their own needs met. Continued research and education on women's lives could assist girls and women to redefine and value themselves as people. This would also help to eliminate the idea that the causes of depression lie within the individual woman, rather than the causes lying within the systems set up which marginalize women and discount their experiences.

The findings in this study support the social learning theory of depression which emphasizes the importance of observing and modelling the behaviors, attitudes and emotional reactions of others. The women all learned, when they were young, that they were supposed to be subordinate and submissive, that goodness equals self-sacrifice, and
they should ignore their own needs. They all developed masks and a false self to present to the world. Corob (1987) states that as adults, women have learned that they should be passive, fearful, submissive, and self-sacrificing which are core components of depression. Due to the abuse, the women in this study seem to have been severely restricted and socialized into "hyperfemininity" where they had to subsume who they were and become what others expected them to be. As the women in this study fought to change from the way they had been socialized, their depression frequently intensified, but remaining in those roles was equally as depressing. These results indicate the need for changing the way in which females are socialized and society's expectations of how women should be.

For women who have been abused as children, the restricted roles and "hyperfeminine" socialization seems to result in extreme sensitivity to conforming to society's expectations at the expense of denying themselves. Feminist research and literature has contributed to this area, but much of what has been written is still considered radical and not included in general education curriculum.

When looking at the results that emerged from the theme Regaining the Self, the women's experiences did not support Beck's (1976) cognitive behavioral theory which states that if people learn new ways of behavior, their mood will increase. This theory presupposes that social factors do not influence mood, behavior and thoughts, however, in all the women's stories, social factors and life experiences influenced their mood, behavior and thoughts. Cognitive behavioral theory and therapy are widely used to treat depressed women, yet is based on androcentric theory developed from male experiences. The findings in this study indicate that cognitive behavior therapy, while it may work well for
some depressed women, does not work for all women. From the women's experiences it seems that social issues need to be addressed in addition to learning new behaviors if therapy is going to be effective.

The women all talked about supports and help, but they all experienced internal struggles with them. One result that emerged was that the women felt only people who had experienced depression really understood the experience. This indicates that support groups, run by facilitators who have experienced depression, could be an appropriate vehicle for working with women experiencing depression. Additionally, as all the women were either reluctant to seek counselling, had poor experiences with counselling, or could not afford private counselling, support groups could be a cost effective method of providing alternate support.

Another result was that all the women identified their doctor as being one of their primary supports, and one of the first people they turned to for help. This indicates the need for education for general practitioners on how women experiencing depression may present themselves, and the struggles they have with the idea of antidepressant medication. All the women talked about the stigma attached to medication, particularly Prozac. This indicates the need for clear, understandable research and education on the changes in brain chemistry and how medication works for the general public. Perhaps this, and removing depression as a classified mental, illness would reduce the stigma and help to eliminate some of the struggles the women faced in seeking help.

The women also included some recommendations that they though would benefit depressed women. They indicated that support groups, specifically for depressed women,
would provide a safe environment where they could learn to open up their feelings without being misunderstood or stigmatized. All the women have an incredibly difficult time talking about their feelings. It is obvious from their interviews that given the opportunity to talk about their feelings and experiences, the women are able to do this and see great value in it. At present, there are groups for women suffering from postpartum depression, and groups for people experiencing depression, anxiety and panic attacks, but none specifically for women experiencing depression where they could learn to regain their voice. This finding indicates a need for such a service.

The women also felt that free, accessible counselling was needed. The only free counselling was through Mental Health or from psychiatrists. The women felt stigmatized utilizing these services, and found that what was provided often did not meet their needs as the services were not woman centred or collaborative in their approach. In addition, the wait lists for Mental Health services were lengthy and the women often found they did not qualify. Some of the women were also concerned about utilizing Mental Health services as they work in the social service field and were afraid that their reputations would suffer if people found out they were seeing someone at Mental Health. Mary, who qualified for counselling through Worker's Compensation also indicated problems such as having to find her own counsellor and set up the services, which she found overwhelming when she was depressed. Some of the women had extended health benefits that paid for some counselling, but many of the women's employers did not offer extended benefits. The women complained that they often did not know what was available, and they did not have the energy to research available services and the approach used. This finding
indicated a need for women centred, free, accessible counselling, which should be well advertised.

Research and resources for First Nation's women, other minority women, and lesbian and bi-sexual women are even more scarce. The two First Nation's women, one of whom was also bi-sexual felt that they faced conflicting messages about who they were, which impacted their depression. Some of the difficulties faced by minority and lesbian women are homophobia, racism, and sexism, which may all contribute to depression. Women centred research that addresses all aspects of every woman's life is vital if women are to heal and reach their potential.

In sum, these women's stories provide us with a deeper understanding of women's experiences with depression, how it has affected their daily lives, their relationships, and their feelings about themselves and their lives. Their experiences indicate that childhood trauma from abuse, being silenced, and socialized to be "hyperfeminine" can result in depression as adults. By understanding women's experiences with depression, social workers and others working in the helping professions will be able to determine where intervention should be focused. Counselling should be woman centred, starting with where the woman "is at." With some women, it may be that the place to start intervention is with offering information on medication and natural remedies and the way they work, while with other women it may be exploring their childhood or relationships. With other women, it may be that looking at the systems that are set up which marginalize women would be the place to start. What is clear is that there are a variety of areas which could be explored, and it is up to individual women to decide where they want their therapy to
focus. By understanding women's experiences with depression, social workers can offer the women the support they need, provide more comprehensive, coordinated supports, and assist with developing programs where children can learn to talk about their feelings. Social workers can also advocate for social change within the structures that marginalize women and their experiences.

These results indicate the importance of listening to each woman's story to understand her experiences and thereby offer appropriate services. I hope that this research will promote interest in additional, much needed research as women are becoming depressed in increasingly large numbers. It may be that some women are experiencing continuing stress, from children through adulthood, as they deal with family, work, school, violence and the threat of violence on a daily basis, and within that stress, loose themselves. Perhaps this indicates a need for research on the effects of continuing stress in women's lives, and the need for women to have a voice about their own experiences.
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APPENDIX A

Ethics Approval
Qualitative research methods will be used as the purpose of the research is to give voice to the reality of women's experiences with depression. Snowball sampling methods, through approaching women who have told me they are depressed, will be used to elicit participants. An unstructured interview format will be used to listen to the women's stories. Open ended questions will be used when questions are appropriate. This phenomenological, descriptive approach assumes that women are reliable witnesses to their own psychological experiences. The participants will determine the location of the interviews. The interviews will be tape recorded to ensure accuracy with transcribing and analysis. Once the interviews have been transcribed and analyzed, the participants will have the opportunity to read the reports and make changes and corrections as they desire. This will insure that their stories are told and interpreted accurately.
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>22. Where will the project be conducted? (Room or area)</td>
<td>The location will be the participants choice.</td>
</tr>
<tr>
<td>23. Who will actually conduct the study and what are their qualifications?</td>
<td>I will actually conduct the study. I have a BSW and eleven years of clinical experience. I have also conducted interviews for establishing a youth center, for program proposals, and for my BSW degree requirements.</td>
</tr>
<tr>
<td>24. Will the group of subjects have any problems giving informed consent on their own behalf? Consider physical or mental condition, age, language, and other barriers.</td>
<td>N/A</td>
</tr>
<tr>
<td>25. If the subjects are not competent to give fully informed consent, who will consent on their behalf?</td>
<td>N/A</td>
</tr>
<tr>
<td>26. What is known about the risks and benefits of the proposed research? Do you have additional opinions on this issue?</td>
<td>It is recognized that talking about painful experiences may be distressing but there is therapeutic value in talking about experiences. There are no known risks but a list of counsellors, community resources will be compiled and available. Referrals will also be made if required.</td>
</tr>
<tr>
<td>27. What discomfort or incapacity are the subjects likely to endure as a result of the experimental procedure?</td>
<td>N/A</td>
</tr>
<tr>
<td>28. If monetary compensation is to be offered to the subjects, provide details of amounts and payment schedule</td>
<td>N/A</td>
</tr>
<tr>
<td>29. How much time will a participant have?</td>
<td>The interviews will end when the participants end them, but will be approximately 2-3 hours.</td>
</tr>
</tbody>
</table>
31. WHO WILL HAVE ACCESS TO THE DATA?

Deborah O'Connor, Mary Russell (Thesis Advisor), and other members of my thesis committee.

32. HOW WILL THE CONFIDENTIALITY OF THE DATA BE MAINTAINED?

The data will be stored in locked cabinets, and password protection will be used on the computer. Separate files will be kept for the transcribed copies, and all identifying information will be removed. Pseudo names will be used.

33. WHAT ARE THE PLANS FOR THE FUTURE USE OF THE RAW DATA BEYOND THAT DESCRIBED IN THIS PROTOCOL? HOW AND WHY WILL THE DATA BE DESTROYED?

It may be used for academic and scholarly publications. All the raw data will be destroyed at the end of the thesis project.

34. WILL ANY DATA WHICH IDENTIFIES INDIVIDUALS BE AVAILABLE TO PERSONS OR AGENCIES OUTSIDE THE UNIVERSITY?

No

35. ARE THERE ANY PLANS FOR FEEDBACK TO THE SUBJECT?

Follow-up interviews will be conducted to ensure the accuracy of the analysis.

36. WILL YOUR PROJECT USE:

- [ ] QUESTIONNAIRES (SUBMIT A COPY);
- [X] INTERVIEWS (SUBMIT A SAMPLE OF QUESTIONS); unstructured, open ended
37. FUNDING INFORMATION

AGENCY / SOURCE OF FUNDS: N/A

FUNDS ADMINISTERED BY:
○ UBC ○ VHHSC ○ SPH ○ BCWH ○ BCCH ○ BCCA

UBC OR HOSPITAL ACCOUNT NUMBER:

STATUS: ○ INTERNAL ○ EXTERNAL

PEER REVIEW: ○ YES ○ NO

START DATE:

FINISH DATE:

INFORMED CONSENT

38. WHO WILL CONSENT?

X SUBJECT.

PARENT OR GUARDIAN. (WRITTEN PARENTAL CONSENT IS ALWAYS REQUIRED FOR RESEARCH IN THE SCHOOLS AND AN OPPORTUNITY MUST BE PRESENTED EITHER VERBALLY OR IN WRITING TO THE STUDENTS TO REFUSE TO PARTICIPATE OR WITHDRAW. A COPY OF WHAT IS WRITTEN OR SAID TO THE STUDENTS SHOULD BE PROVIDED FOR REVIEW BY THE COMMITTEE.)

AGENCY OFFICIAL(S).

39. IN THE CASE OF PROJECTS CARRIED OUT AT OTHER INSTITUTIONS, THE COMMITTEE REQUIRES WRITTEN PROOF THAT AGENCY CONSENT HAS BEEN RECEIVED. PLEASE SPECIFY BELOW:

○ RESEARCH CARRIED OUT IN A HOSPITAL - APPROVAL OF HOSPITAL RESEARCH OR ETHICS COMMITTEE.

○ RESEARCH CARRIED OUT IN A SCHOOL - APPROVAL OF SCHOOL BOARD AND/OR PRINCIPAL. EXACT REQUIREMENTS DEPEND ON INDIVIDUAL SCHOOL BOARDS; CHECK WITH FACULTY OF EDUCATION COMMITTEE MEMBERS FOR DETAILS.

○ RESEARCH CARRIED OUT IN A PROVINCIAL HEALTH AGENCY - APPROVAL OF DEPUTY MINISTER.

○ OTHER, SPECIFY:

QUESTIONNAIRES (COMPLETED BY SUBJECTS)

40. QUESTIONNAIRES SHOULD CONTAIN AN INTRODUCTORY PARAGRAPH OR COVERING LETTER WHICH INCLUDES THE FOLLOWING INFORMATION. PLEASE CHECK EACH ITEM IN THE FOLLOWING LIST BEFORE SUBMISSION OF THIS FORM TO INSURE THAT THE INSTRUCTION CONTAINS ALL NECESSARY ITEMS:

○ UBC LETTERHEAD.

○ TITLE OF PROJECT.

○ IDENTIFICATION OF THE INVESTIGATORS, INCLUDING A TELEPHONE NUMBER.

○ A BRIEF SUMMARY THAT INDICATES THE PURPOSE OF THE PROJECT.

○ THE BENEFITS TO BE DERIVED.

○ A FULL DESCRIPTION OF THE PROCEDURES TO BE CARRIED OUT IN WHICH THE SUBJECTS ARE INVOLVED.

○ A STATEMENT OF THE SUBJECT'S RIGHT TO REFUSE TO PARTICIPATE OR WITHDRAW AT ANY TIME WITHOUT JEOPARDIZING FURTHER TREATMENT, MEDICAL CARE OR CLASS STANDING AS APPLICABLE. NOTE: THIS STATEMENT MUST ALSO APPEAR ON EXPLANATORY LETTERS INVOLVING QUESTIONNAIRES.

○ THE AMOUNT OF TIME REQUIRED OF THE SUBJECT MUST BE STATED.

○ THE STATEMENT THAT IF THE QUESTIONNAIRE IS COMPLETED IT WILL BE ASSUMED THAT CONSENT HAS BEEN GIVEN. THIS IS SUFFICIENT IF THE RESEARCH IS LIMITED TO QUESTIONNAIRES; ANY OTHER PROCEDURES OR INTERVIEWS REQUIRE A CONSENT FORM SIGNED BY THE SUBJECT.

○ AN EXPLANATION OF HOW TO RETURN THE QUESTIONNAIRE.

○ ASSURANCE THAT THE IDENTITY OF THE SUBJECT WILL BE KEPT CONFIDENTIAL AND A DESCRIPTION OF HOW THIS WILL BE ACCOMPLISHED; E.G. 'DON'T PUT YOUR NAME ON THE QUESTIONNAIRE'

○ FOR SURVEYS CIRCULATED BY MAIL SUBMIT A COPY OF THE EXPLANATORY LETTER AS WELL AS A COPY OF THE QUESTIONNAIRE
CONSENT FORMS

41. UBC POLICY REQUIRES WRITTEN CONSENT IN ALL CASES OTHER THAN THOSE LIMITED TO QUESTIONNAIRES WHICH ARE COMPLETED BY THE SUBJECT. (SEE ITEM #40 FOR CONSENT REQUIREMENTS.) PLEASE CHECK EACH ITEM IN THE FOLLOWING LIST BEFORE SUBMISSION OF THIS FORM TO ENSURE THAT THE WRITTEN CONSENT FORM ATTACHED CONTAINS ALL NECESSARY ITEM IF YOUR RESEARCH INVOLVES INITIAL CONTACT BY TELEPHONE, YOU DO NOT NEED TO FILL OUT THIS SECTION.

☒ THE CONSENT FORM MUST BE ON UBC LETTERHEAD.

☒ TITLE OF PROJECT.

☒ IDENTIFICATION OF INVESTIGATORS, INCLUDING A TELEPHONE NUMBER. RESEARCH FOR A GRADUATE THESIS SHOULD BE IDENTIFIED AS SUCH AND THE NAME AND TELEPHONE NUMBER OF THE FACULTY ADVISOR INCLUDED.

☒ BRIEF BUT COMPLETE DESCRIPTION IN LAY LANGUAGE OF THE PURPOSE OF THE PROJECT AND OF ALL PROCEDURES TO BE CARRIED OUT IN WHICH THE SUBJECTS ARE INVOLVED. INDICATE IF THE PROJECT INVOLVES A NEW OR NON-TRADITIONAL PROTOCOL WHICH HAS NOT BEEN PROVEN IN CONTROLLED STUDIES.

☒ ASSURANCE THAT THE IDENTITY OF THE SUBJECT WILL BE KEPT CONFIDENTIAL AND DESCRIPTION OF HOW THIS WILL BE ACCOMPLISHED, I.E. Describe how records in the principal investigator's possession will be coded, kept in a locked filing cabinet, or under password if kept on a computer hard drive.

☒ STATEMENT OF THE TOTAL AMOUNT OF TIME THAT WILL BE REQUIRED OF A SUBJECT.

☐ DETAILS OF MONETARY COMPENSATION, IF ANY, TO BE OFFERED TO SUBJECTS.

☒ AN OFFER TO ANSWER ANY INQUIRIES CONCERNING THE PROCEDURES TO ENSURE THAT THEY ARE FULLY UNDERSTOOD BY THE SUBJECT AND TO PROVIDE DEBRIEFING, IF APPROPRIATE.

☒ A STATEMENT THAT IF THEY HAVE ANY CONCERNS ABOUT THEIR RIGHTS OR TREATMENT AS RESEARCH SUBJECTS, THEY MAY CONTACT DR. RICHARD SPRATLEY, DIRECTOR OF THE UBC OFFICE OF RESEARCH SERVICES AND ADMINISTRATION, AT 822-6550.

☒ A STATEMENT OF THE SUBJECT'S RIGHT TO REFUSE TO PARTICIPATE OR WITHDRAW AT ANY TIME AND A STATEMENT THAT WITHDRAWAL OR REFUSAL TO PARTICIPATE WILL NOT JEOPARDIZE FURTHER TREATMENT, MEDICAL CARE OR INFLUENCE CLINICAL STANDING AS APPLICABLE. NOTE: THIS STATEMENT MUST ALSO APPEAR ON LETTERS OF INITIAL CONTACT. FOR RESEARCH DONE IN THE SCHOOLS, INDICATE WHAT HAPPENS TO CHILDREN WHOSE PARENTS DO NOT CONSENT. THE PROCEDURE MAY BE PART OF CLASSROOM WORK BUT THE COLLECTION OF DATA MAY BE PURELY FOR RESEARCH.

☒ A STATEMENT ACKNOWLEDGING THAT THE SUBJECT HAS RECEIVED A COPY OF THE CONSENT FORM INCLUDING ALL ATTACHMENTS FOR THE SUBJECT'S OWN RECORDS.

☒ A PLACE FOR SIGNATURE OF SUBJECT CONSENTING TO PARTICIPATE IN THE RESEARCH PROJECT, INVESTIGATION, OR STUDY AND A PLACE FOR THE DATE OF THE SIGNATURE.

☐ PARENTAL CONSENT FORMS MUST CONTAIN A STATEMENT OF CHOICE PROVIDING AN OPTION FOR REFUSAL TO PARTICIPATE, E.G. "I CONSENT / I DO NOT CONSENT TO MY CHILD'S PARTICIPATION IN THIS STUDY." ALSO, VERBAL ASSENT MUST BE OBTAINED FROM THE CHILD, IF THE PARENT HAS CONSENTED.

☐ IF THERE IS MORE THAN ONE PAGE, NUMBER THE PAGES OF THE CONSENT, E.G. PAGE 1 OF 3, 2 OF 3, 3 OF 3.

ATTACHMENTS

42. CHECK ITEMS ATTACHED TO THIS SUBMISSION, IF APPLICABLE. INCOMPLETE SUBmissions WILL NOT BE REVIEWED.

☐ LETTER OF INITIAL CONTACT. (ITEM 20)

☐ ADVERTISEMENT FOR VOLUNTEER SUBJECTS. (ITEM 20)

☒ SUBJECT CONSENT FORM. (ITEM 41)

☐ CONTROL GROUP CONSENT FORM. (IF DIFFERENT FROM ABOVE)

☐ PARENT/GUARDIAN CONSENT FORM. (IF DIFFERENT FROM ABOVE)

☐ AGENCY CONSENT. (ITEM 39)

☒ QUESTIONNAIRES, TESTS, INTERVIEWS, ETC. (ITEM 36)

☐ EXPLANATORY LETTER WITH QUESTIONNAIRE. (ITEM 40)

☐ DECEPTION FORM. (INCLUDING A COPY OF TRANSCRIPT OF WRITTEN OR VERBAL DEBRIEFING)

☐ TELEPHONE CONTACT FORM.

☐ OTHER, SPECIFY:
APPENDIX B

Interview Consent Letter
Interview Guide

1. What have been your experiences with depression?

2. What do you think has contributed to your depression?

3. What services do you think are necessary?
APPENDIX D

Interview Transcript
INTERVIEW WITH MARY

1. Me: What have your experiences been with depression?

2. M: Oh huh well I know where it comes from
   like my history and stuff uh growing up with an abusive family
   and uh that
   and the dealings with it
   I've been in and out of hospital alot
   when I was younger it was always for suicide attempts
   but it wasn't necessarily that I wanted to kill myself
   but it was the only way I could ask for help without actually
   asking
   um - but as I've gotten older - I've - been able to deal with it
   I notice it coming on so I've been able to ask for the help I need
   and stuff
   --- It it uh --- it's a it's a hard thing to describe um---
   I guess because I've never really thought about it in all this time
   ---um but I've I've been through uh like all the counselling
   to several different counsellors and through Mental Health
   - um and through hospital programs and stuff---
   um but I could say that when I was younger I didn't deal with it
   head on as depression
   It was uh It was like cause it's always like it's always been
   the doctors and stuff have all classified it as anniverserial
   and seasonal depression
   which basically is uh --- like uh
   the times that are the worse for me I'll start with that
   are are the times that the disclosure about the sexual abuse
   came out um
   which is May, the beginning of May is really really hard for me
   and Christmas is one of the worst times of the year for me uh
   just cause Christmas was never really good for our family
   like my mom and dad my brother and I, not like my whole
   extended family but um
   so those are the worst times of the year for me
   and they say Christmas because of the season like a lot of
   people get depressed around Christmas and stuff so
   I feel it has more to do with my family issues and um---
   the May is really hard for me like I say because that is the
   time that I lost my family um that's the time that um---
   ---um that the disclosure was made ---
40Me: What do you mean by you lost your family?

41M: Well um my dad left us and I had to move in with my aunt and 
42 uncle um until my mom was stable in her own house 
43 without my dad 
44 so that was really hard it really felt like I lost my family for a 
45 period of time cause I wasn’t allowed to visit my mom 
46 just my mom and I somebody always had to be with us 
47 and uh I literally lost my dad which is good because of the 
48 abuse and stuff but it was also really hard and stuff 
49 because --- I lost somebody in my life who was like a 
50 dad 
51 basically um --- so those times of the year are really really 
52 difficult 
53 and I don’t I know why I get depressed 
54 I know what triggers it now um and stuff 
55 but it was really hard growing up because I I never realized it 
56 it was always a bad time of the year and I just accepted it kinda 
57 thing 
58 um----- I’m at a loss for words almost 
59 so um---but I’ve been through like I say psychiatrists 
60 psychologists and they’ve tried me on different 
61 antidepressants that didn’t work and uh and stuff like that so it 
62 was really it was a hard it still is a hard process to go 
63 through trying to figure everything out and get it all 
64 sorted out in your own head with why it happens and uh 
65 stuff like that um-----

66Me: When you say that you know what triggers it, can you talk 
67 about that?

68M: well I know why I get depressed when I do now 
69 like I know that May is going to be a bad time of the year for 
70 me because of the separation of the family and stuff so that’s a 
71 trigger for me there like um the month itself 
72 like there’s a lot of my birthday’s in that month and uh--- 
73 it’s just a really hard month cause like I say I feel like I lost 
74 a lot 
75 you know I lost my brother for for a long time too 
76 he doesn’t he didn’t want anything to do with me for a long 
77 time which was very difficult 
78 he blamed everything on me the separation of the family and 
79 um everything
so that’s a trigger
he himself is a trigger which I feel bad about but it is
it’s just a fact because he reminds me so much of my dad
which isn’t fair to him—-you know in a sense
but in another sense I can’t help it
It just happened that way and uh---
---oh I don’t know I can’t put it into words
--- I just I just know that that’s a bad time of year for me
you know what I mean like uh
I prepare myself for it when it comes up and stuff and uh
---little things set me off at that time too like uh---
I think a lot a a I turned my depression into anger for a long
time
and that’s one of the things I’m dealing with now is
learning that uh --- that I don’t have to get so angry

Me: When you say you turned it into anger, was that anger with
yourself, or anger with other people?

M: With the world literally like um - I I what I used to tell my
doctor all the time and the nurses in the hospital and stuff
is that I did anger, I liked anger um
it was my way of coping without feeling like I was losing it
like I was if I was angry I couldn’t be depressed
so I stayed angry as long as I could
um which was really difficult um
but I’m learning how to deal and manage with that now
I uh I was angry with the world you know like
somebody could look at me the wrong way and I would
explode
I I never violent I was never physical but uh
and it was usually with men you know
like I would never ever ever ever ever back down
from a man
never um and I always seemed to get a lot angrier at them
and I know why I know it was because of the abuse and
uh stuff like that and uh
I had one man in my life hurt me enough and there was no
way another man was going to kinda thing
so my guard was always up
and literally I did anger I was always mad unless I was drinking
and doing drugs
I did that a lot to to escape from everything so uh
but you mixed alcohol with the men I was angry at and it just
wasn't a good situation you know so
but I I thrived on being angry literally that kept me going for a
long time
and then I’d have a break down um
where I guess I was just too tired of being angry
it took too much energy and um I’d slip into the depression
from one extreme to the other you know within minutes kind of
thing
and uh and I did it very well

131 Me: that worked for a long time

132 M: It did it really did it was really scary though
you know at the time it wasn’t so bad but now when I look
back upon it like I did a lot of damage to myself not
physically but emotionally you know
like physically too with the drinking and stuff and uh
cause I’d stuff it all I wouldn’t
people could tell from my facial expressions that I was angry
or upset about something but I wouldn’t project it
I wouldn’t necessarily say it unless something was said to me
first
and in the last little while it’s been everybody and anybody
I just got angry and would quite lose it

144 Me: So it had been a while since you had been doing the anger
and lately you’ve been doing it again?

146 M: Yeah, yeah over the last probably six or seven months
quite, quite angry
like my main thing is driving I can’t drive very well anymore
I get really like if anybody does anything stupid I I let them
know um
but then also I’ve been in the depression too over the last few
months
I think I kinda realized it was building up because of how angry
and stuff I was getting so easily

155 Me: So anger is one of the signs that you get that you’re starting to
get depressed?

157 M: Yeah I get really tense really easily and I do I get really angry
about stupid well I feel it’s dumb kinda stuff like stuff that most
people wouldn’t
I mean you get upset about it when somebody does something
on the road that their taking too long, or their only
doing seventy in an eighty like most people get upset
about it but I’ll yell and scream in my car like
a couple of times I’ve gotten out and said stuff to
people but I just you know
and it’s scary because I really think if I was confronted
I get so mad lately or I was getting so mad that uh I
probably would have reacted physically

So a fear of losing control

Yes yeah and then I realized that I was - getting into a
depression again and that I needed help and stuff

So what other signs do you get that you’re starting to get
depressed?

I just stop caring um ----
to be really honest right now if the health board were to come
to my house they would probably literally condemn my
apartment
I really believe that it’s not an exaggeration it’s

So you just give up on all the house stuff?

everything in life in general you know it just
I just don’t care anymore
it feels like what’s the point
um---I don’t think suicidal thoughts anymore so much
they’re they’re times when I really wish ---
that nobody around me loved me and stuff cause that would
make it easier just to go away
not to necessarily die just to go away from everything and
everybody and um stuff like that
---but another sign like I say I do I literally I don’t care about
anything, nothing
I just kind of exist and that’s what it feels like
is just existance
Me: That must be pretty hard for you like in school or working

M: Yeah that’s one of the reasons I’m taking time off work right now um is just because I did I realized a little later into the depression, like a couple of months that I just couldn’t cope I was doing stuff at work um --- that I’m working on right now uh --- cause I didn’t care and it feels really crappy to say because I love my job and I love the people I work with and --- however since I didn’t care I was almost hoping I would get fired from my job so that I didn’t have to care about it any more um—which to me if anybody didn’t know kind of um about me it might sound really sick um but it’s just how I feel right now

Me: It’s hard to care about other people when you can’t care about yourself.

M: It’s really hard and I’m lucky that I have a lot of people around me to support me and stuff but it’s still really difficult I mean one of the main reasons I started my day program and stuff ---well no okay the reason I started going to see a counsellor is is a he he’s actually a drug and alcohol counsellor but I see him for gambling and stealing it’s just um---that’s what I did at my job I stole and that feels really crappy really crappy um ---but I’m getting help for it now for that anyhow like the stealing was because of the gambling and the gambling was linked to the depression in what they call a um a uh a impulse control disorder what they’re labelling it basically like when I go into depressions it’s like the impulse control part of my brain literally shuts down um ---

Me: That’s how they label it. How do you see it?

M: ---Not caring.----just afraid of going into work every day and having that responsibility when I didn’t even care about myself um I felt like a machine and I felt like I was doing it -- it was never planned out
like um like I didn’t go into work and say okay I’m going to
do this today it just you know if we were out it just kind of
happened you know like
and it did it felt like when I look back at it
at that point in time I couldn’t honestly tell you why I did it
I mean I know that I did it, I know I stole because I needed
the money because of the gambling cause I’d spend all my
money on the gambling um but I couldn’t tell you why
I was gambling and stuff it uh it was the only
the things I have a problem with is bingo and I was
there—pretty much every whenever I wasn’t at work as much as
possible and uh---

Me: Did you find that bingo was like a stress reducer you could
just go and

M: Yeah

Me: You didn’t have to think

M: You didn’t have to think about anything but concentrating on
what you were doing um
It was in some ways a stress relief but an escape in a lot of
other ways you know
like I know a lot of the people that work there and stuff
and it was a place where I could just go and ----uh not care
just exist kind of thing so

Me: You said that you have people around for support. Did you
always have that?

M: Yeah, yeah. It’s been my aunt and my mom um
Over the last few years it’s been my boyfriend um and family
and my doctor, my doctor’s always supported me um
well I mean since I was twelve so for the last thirteen years
so --she’s
I don’t have a medical file I have a medical book
mainly for depression like most of the stuff is for depression and
stuff like that so

Me: When you disclosed the abuse, did you get some counselling at
that time?
266M: Yeah yeah well the actual disclosure was uh uh
267 a friend of mine and I were sitting watching a show called
268 Something About Amelia and it was a show about a girl that
269 was abused by her father and uh
270 when I think back on it I uh I didn’t necessarily purposely
271 say anything out loud but I was thinking out loud kinda
272 I don’t remember the exact words but it was something to do
273 with you know that’s happening to me kind of thing and
274 uh of course she told her mom and her mom told the school
275 and then the school phoned the police and it kinda snowballed
276 from there
277 so I didn’t really have much of a choice like I
278 I didn’t have to say anything at that um if I didn’t want the
279 disclosure to happen I could have denied it all but I didn’t have
280 the choice of going to the police, they were there so it was a
281 safety net right there and um I didn’t when it when I very very
282 first disclosed I had the police there and they believed every
283 thing I said but the counsellor that came in from the high school
284 because of course back then elementary schools didn’t have
285 counsellors didn’t need counsellors so they thought
286 and uh she was really hard on me she was really she
287 twisted a lot of what I said around um I don’t know it it was
288 because she didn’t believe me or if she was trying to be hard to
289 get to make sure I was telling the truth kind of thing
290 but she was she asked me like if if it was incest and
291 I mean I was twelve years old I didn’t I’d never even heard the
292 word before kind of thing but I said yes
293 It sounds right and then she turned around and said what does
294 it mean um not in those exact words but you know basically
295 wasn’t asked that nicely so and then I drew a blank so she
296 accused me of lying right then and there basically but the police
297 were there and they stopped that right away so I had the police
298 on my side the whole time and they when they disclosed to my
299 mom um I wasn’t there I was still at the school the police went
300 and talked to my mom and uh she never ever once said that
301 she doubted me you know there was never--she’s she’s said
302 that she didn’t want to believe me which I can fully understand
303 I mean who would want to believe that somebody that they
304 loved could do something that sick and uh
305 of course when my dad came home and she confronted my dad
306 see this is I got taken away from my mom like they brought me
307 home after they disclosed to my mom after they talked to my
308 mom about it to get some of my stuff and then my uncle came
and picked me up and took me to and my brother there to
their place um but I wasn’t allowed to talk to my mom really
other than to give her a hug and say goodbye kind of thing
like we weren’t allowed to discuss anything so I don’t know if
she didn’t believe me then kind of thing when it was first told
to her and I’m kind of glad that they didn’t let me because if she
would of not believed me that that would have been really
devastating for me without her there, it would have hurt more
that anything but after I was taken away and then a few days
later my dad came home because he was working out of town
and uh she phoned the police on the day that he was due back
and the police were there and as he was being arrested and
taken away um this is what my mom tells me she he turned
around and told her that basically that I came on to him and
from then obviously from that day forward she’s never had a
doubt in her mind you know she’s always always always
backed me up so I’m really lucky because I’ve talked to a lot
of people that haven’t had that support so there’s been no doubt
and all the psychologists and psychiatrists um from what I
understand all the psychiatrists that were—all the ones that
were—from my lawyer um I don’t know um all the ones for
the prosecutor um I know that they had no doubts I know that
uh—you know cause I read some of the reports and stuff when
I was older um and I got the feeling in the office you know just
talking and stuff that there was no doubt in their minds and um
from doctors reports and stuff too they all backed up what I
was saying medically um and I think, I don’t know for a fact
I never saw the report on this one but the psychiatrist that um
my dad’s lawyer hired when we went in to see him he kept
asking me well what if they said that you were lying he asked
me that at least half a dozen times in a row you know and I
kept telling him that I wasn’t lying I was telling him the truth
and he kept going on and on and on and finally I think I got
mad, well I know I got mad and I turned around and told him
to fuck off and walked out of his room and uh
I don’t like I say I don’t know I think he was asking me like
that to get a rise out of me to see if you know I would break
down and um—but I didn’t cause I wasn’t so I think I got a
good report I don’t I don’t know the right terminology to use
but you know report back on me from him too but I don’t
know this because I didn’t see his report kind of thing um
Me: Being abused was one of the things you learned not to talk to people about your feelings or what was happening for you?

M: Um --- yeah um but I also got into counselling right away like literally right after the court, well I was going for counselling even before because they helped get the kids ready for court and stuff and support the kids all through it and stuff and I I had a really good lawyer but uh that supported me as well but uh I got into counselling right after that and some of the counsellors well most of the ones I went through through mental health were all you know they’d see you for a couple of weeks and as soon as they saw a smile on your face they’d pat you on the back and they said I was fine and didn't need to come anymore and uh --- that kind of turned me off of counselling for a while because it was well you have one good day and you're fine No so I kind of shut down and that’s when I when I shut down that’s when I’d end up in the hospital first it was for suicide attempts and stuff--- when I was younger in the hospital they never really had like they had OT’s and stuff like that but it was there was no real counselling per se but now when you go in there they've got groups for everything

Me: So things have changed over the years?

M: Oh big time big time.

Me: Do you find it more helpful now with the groups?

M: Yeah cause right now I’m in the day program through the hospital and that’s uh --- in the mornings we work on assertiveness, and anger management and stress management and then in the afternoons there's all different groups that teach us leisure skills like that it's okay to unwind and do something that you want to do there’s a wellness where they teach the affirmations which that’s the one that I’m having the most problems with is the self affirmations It doesn’t work. It doesn’t work just yet.
Me: So you’re still not feeling very good about yourself?

M: No, no um I uh I’m feeling better
I never really liked my like I like myself
I like my personality when I’m not in a depression
but I’ve never really liked myself um
I think because for so long I was so worried about being
what everybody else thought I should be -- that uh
I never really let me be me until I went into a depression
and then it was like I didn’t care

Me: Where do you think that idea came from? That you have to
be what everyone else want’s you to be.

M: From the abuse like I I guess we were never allowed to be
angry or be upset or show what we really felt
we always had to be happy and carry on with a smile
you know and that’s what I did growing up
and through my teenage years and stuff
you know I’d be so overly happy on the outside
but on the inside I was just feeling like crap
but any time I let that show everybody would be like Oh my
God you know throwing this big panic and
I would just crash----
but---now and then and then I went into the anger thing
I did I dunno and that was mainly directed at guys
like I say that was when I was drinking and
things got really bad
well first after the disclosure and stuff I was really shy
and I was the kid in the high school and stuff that everybody
picked on that everybody hated you know
I was the poor little fat girl and stuff like that um
so I never really---expressed feelings or anything
I was in the counsellors office a lot um---
but I never really got to show people who I was
and then when I moved from that school to a different school
there was a few people that knew me from when I was in
Army Cadets and remembered what I was like then
that I was happy and stuff---
so then I put on that face that mask like I was always always
always happy If anybody needed to hear anything funny they
always knew who to come to
and nobody had ever seen me upset
no one had ever seen me mad
well okay that’s not true um---
I was also happy and hyper and spinnny but on the other hand
I think that nobody really ever saw me really mad
because they were afraid of me
I put on a show
I may have been happy but watch out I’m really tough
even though I’d never done anything physically to prove it
just my size and the way I dressed
I started wearing black harley T shirts and the black spandex
clothing you know

Me: So you sent out the message stay away, don’t get too close

M: Yeah and then I unless I picked you you know
which may sound really conceited and stuff
but I had I had a lot of people that considered me friends
in high school but I never had a lot of friends
like a lot of really really close friends

Me: Close people that you would open up to?

M: yeah there’s two that or three that were really close to me
and that was I literally let them you know
like anybody else I kind of acted the tough toward
like don’t get too close to me, like yeah I’ll talk to you and
you can be my buddy but

Me: So shut yourself off play the role that people want to see

M: Exactly yeah

Me: So it sounds like control was also an issue for you

M: Yeah, well I never had a lot of control growing up and this is
the way that I could because it was the way I was shown
growing up
if everybody thinks your tough, if everybody thinks your
that your always positive that that uh---they they kind of
leave you alone
Like they kind of like you or they like what they know about
you or what they see of you but they never really take the time
to get to know you
Me: Was that the message you got from both your parents to be tough and

M: No, my mom didn’t know about the sexual abuse. She knew about the physical abuse but she was going through it too, you know, and the emotional abuse and everything like that. But she never, never really saying the actual words, she was just telling you that you have to be tough, you have to do this. You have to be strong. Never not enough really saying the actual words.

Me: Just the impression that this was how to do it.

M: Yeah, yeah, you have to be tough and if you’re not, then people are going to walk all over you.

Me: So you grew up in a home with physical abuse towards you, your mom and your brother and emotional abuse and sexual abuse toward you and the idea that you didn’t talk about your feelings, you didn’t open up, you were however you needed to be in that situation.

M: Yeah, yeah, exactly, but meanwhile, inside you’re just eaten up. You’re just really hurting, but it’s like you have this bottle inside you and every time you stuff something, every time something happens you don’t talk about it, you keep it inside you and you keep stuffing and stuffing and then it’s like you hit this depression and the bottle just explodes.

Me: And then what happens with all the stuff inside the bottle when it explodes?

M: What I choose to let out comes out. It’s funny because even when I’m in a depression, people only hear what I want to tell them. It’s just the way it is. Now I’m starting to open up a lot more now that I’m older. I can see that this is for my benefit. That I just talk about what I need to talk about, not just pick what I want to kind of thing. Um, cause that’s what I did for a long time. Plus I told people what I thought they wanted to hear.
even if it was true that—they---when I was first in groups
through the hospital um it was all negative stuff
it was all they only wanted to hear negative stuff so even if you
were having a good day or something good was happening
you didn’t talk about it
and to me that felt like it was stuffing it too
because I would get angry that I couldn’t share something
and then they’d ask me why I was angry and I couldn’t tell them
cause it’s not what they wanted to hear

Me: So that wasn’t particularly helpful

Yeah, even though I’m sure that even if I’d opened up and
shared it that I would be allowed but I felt like
all they wanted to hear about was my abuse and the negativity
around that so I never shared anything else
whereas now I know that the good comes with the bad
you know and if something good is going on like it’s okay to let
them know because they’re just cause one good thing happens
they’re not going to turn around and say you’re fine
and it’s it’s really difficult because I grew up for so long
only saying what I thought people wanted to hear which
felt right at the time it was the easiest thing to do at the time
but meanwhile I was getting more and more depressed

Me: Do you think that part of that came from being female too
and the ideas about how females are supposed to be?

I’ve never really thought about it that way um
in I guess in some ways yes um---
cause I’ve always grown up with women are so much more
emotional anyway and that that was just a fact of life
kind of thing
and most of the groups that I’ve been with that I’ve been in
until now have been all female groups uh
but I I think I just totally lost the question
I think um-----I don’t know if it’s I don’t think my depression
has to do directly with just being female in general uh
sometimes I think if I wasn’t female that none of this would
have happened to me and that maybe I wouldn’t be depressed
then but I’ve never really thought it’s just because I’m female
Me: I guess I didn’t mean it in the sense that just because you’re a woman, but also because your female and raised in a society where there are messages about how females are supposed to be and act. You know like all the media messages about being thin and beautiful.

M: When I was younger uh—that was harder for me than it is now um I guess partly because I know that I can be loved no matter what but I’ve always been overweight from what I can remember you know with my teen and that kind of thing um and that I guess in some ways has had a role in it just cause I always used to wish that I could look like them I mean it was upsetting that people would judge you just because of the way you looked and I always got picked on because of the way I looked um and stuff but when I went into depressions I would always gain more.

Me: You would eat more when you were depressed?

M: Oh yeah, I’m a binge eater not like anorexia or bulimia or anything like that I’ve never most most people when they binge throw up or do the laxative thing I never, I just keep stuffing my face you know until I hurt until I physically hurt and then I’d stop and um—but I’ve never been able to society as a whole or not as a whole um I guess not I guess when I look at it in some ways maybe yeah um because I was ridiculed a lot and stuff my boyfriend and I have had a lot of talks about it and uh he’s worried abouht my health um but he’s not worried about the way I look you know or anything like that that’s not a big issue I would like to loose weight and be uh like more like I guess I don’t shop very often or I didn’t shop very often because it was depressing it was really I always had to shop in the plus sizes or when I was twelve years old I couldn’t wear what 12 year olds were wearing I had to go to the ladies sizes and stuff and
yourself

573M: yeah but I guess I just learned to deal with it

574Me: Deal with it how?

575M: ---that’s a tough question I used to make jokes about myself
576 I used to if anybody would bug me I’d be like yeah
577 I’m not overweight I’m under tall you know
578 stretch me out and I’d be just fine um
579 I guess that’s mainly how I’d if anybody had anything negative
580 to say about the way I looked I’d switch it around

581Me: I guess what I was wondering though was how do you deal
582 with it under that?

583M: I guess I never really did It’s I don’t know---
584 that I mean that could very well be one of the reasons I do go
585 into a depression or not
586 that could be a trigger um
587 but I’ve never really thought about it that way before
588 I guess because I’ve grown up with it and lived with it for so
589 long it was my protection and then it just became a habit
590 and I’d feel hurt when people picked on me
591 but generally speaking I mean other than like my family and
592 stuff that would cousins would tease and I would take it as
593 I would be hurt and be upset about it but take it as teasing
594 um and if it was somebody that I didn’t know --- I would
595 be like well they don’t know me you know like they don’t
596 accept me
597 but it did hurt I guess when I’m feeling okay like when I’m
598 not in a depression um I generally confident enough about
599 myself to know that they don’t know me and I don’t let it
600 get to the point where it does hurt me so I don’t think---
601 society I don’t let rule me I guess maybe I don’t take too much
602 of what society has to offer to heart um
603 see I’m lucky I’m I got into the counselling and stuff right
604 away and into the I’m okay you’re okay kind of thing right
605 away um---so it wasn’t--- I don’t know how to explain it
606 I never really cared about what society had to say personally
607 and I never I really didn’t let it bother me like it would hurt
608 like any sort of kid being teased about anything hurts uh
609 but it never got past that and I don’t know if it was because I
wondered it um or if it was just because that’s the way it was

Me: How did you stop it from hurting?

M: I would just think of the source that it was coming from and I always remember people telling me that obviously if someone’s picking on you it’s because they don’t have enough self esteem themselves and I guess that’s something that’s always stuck with me that if somebody is going to bug you about some thing that is not perfect with you then they’re not feeling good about themselves and I guess cause like I say I always grew up with that was something I was always told by my mom and by counsellors you know if I ever brought it up or anything like that and that’s something that’s really stuck with me and I really believe that cause I know I pick on people you know like if I’m having a bad day and I don’t feel well about myself if somebody walks by me and they’re wearing an ugly shirt or something that I don’t like I’ll I won’t say something to them necessarily but like it goes on in my head and it’s but if I’m having a good day and I see it I don’t even think about it

Me: So lots of it is just how you’re thinking

M: Yeah yeah

Me: So it sounds like getting into counselling really gave you some skills to be able to deal with some of the stuff

M: When I chose to use them um there’s a lot of times that --that I mean ---people counsellors and stuff would say okay like you know we should sit down and do this or we should work on this and stuff like that and I’d go yeah yeah yeah yeah and like I said I’d tell them\ what I’d think they wanted to hear but I wouldn’t listen to what they were actually saying ---so that in itself didn’t work well

Me: So counsellors in some respects helped and in others didn’t You stopped if you didn’t want to go that far

M: Yeah yeah and it was --- they tried sending me to a couple of male psychiatrists that just didn’t work and I think that was a big block for me was if if there was any
sort of male involved that was it
it would stop right there
you heard very little I said very little you know
you could ask me a question and I’d talk all around the
question but I’d never answer it
it was uh—it wasn’t that I was ashamed of myself per se
about being sexually abused um I was told right from the
beginning that it was never my fault and I always believed that
it was never my fault
but it it’s really hard to open up to a guy about it cause you
kind of wonder what’s going through their head
and I always think when I’m talking with somebody about it
about what their thinking about what I’m saying --
so for guys in particular they must be thoroughly disgusted
that was my big thing uh --- when I was a teenager with
girlfriends and stuff um—I was always really careful because I
always thought what would they think of ME if they knew
that this had happened to me
all my male friends I had a lot of male friends when I was a
teenager they were my best friend kind of thing was mainly guys
which is really weird cause ----I had a harder time uh----
I can’t think of the right words for it it’s like if you were a
professional a psychiatrist or somebody and I had to pour my
guts out to you I couldn’t because I’m always worried that
they’re oow you know kind of thing but I could relate to my
male friends better um it was easier to be me---
well it was easier to be who I wanted to be around the guys
you know it was more comfortable and I was always the one
that would tell the sick jokes and stuff like that which ---

Me:Was it easier do you think to set the boundaries with your male
friends than perhaps with female friends who might try to come
in closer?

M: I think so I think so and uh I was quite promiscuous too
um because I thought I grew up with if somebody loved you
that’s what they did even if it was friends family kind of thing
whatever and uh----
but my male friends never expected anything like that from me
never it was it was just a lot easier
there were no worries they didn’t bug me about my size ever
you know like they didn’t try and tell me that I should diet
or change this about me
or like a lot of female friends will sit there and uh

even though they’re your friends they’ll still criticize you

in personal ways in how you look or you know you’ve gotta

get dressed up because the girls are going out where

with the guys it was always casual and comfortable

just hanging out and that was a lot easier for me

there was no competition, no worries about anything

you know no expectations I guess you could say

it wasn’t sexual you could just be whomever and just be friends

and they weren’t into getting right into emotional what’s going

on with you or try to help you with something

just it’s just you could be I can remember one friend of mine he also

had a messed up life so he understood—I didn't feel judged by him

and he didn't try to get into my head the way females try to

I would eventually open up to some of my friends if if I felt like

the friendship the relationship the friendship um---I don’t know

if needed is the right word but came to that point

I guess you could say and I had one friend that uh--right from

almost the beginning of our friendship we just hit it off really

really well and he knew about everything um ---you know

from we used to go for coffees at like 3o’clock in in morning

you know ---he had a lot of problems growing up too kind of

thing so there was a mutual respect um there and um I mean

him and I used to do the craziest things we used to oh it was

great we used to sit on this it’s a little walking bridge um

just over a water fountain and um he would sit with his feet in

the water and lean back and then I would lay across the bridge

and this is like 3o’clock in the morning with my head on his

stomach like a pillow and we’d sing and there was so many

times that the police used to come and you know like are you

guys okay have you been drinking have you been doing drugs

and we were totally straight but we were totally free and it was

the best feeling in the world you know it was---

Me: You say that that was at 3o’clock in the morning. Was part of

the depression having problems sleeping?

M: um---sometimes---um I would get my mind would get like if

say for instance um---uh I’m trying to think of ---

you have a bill to pay you get a disconnection notice whatever

kind of thing and it like I would start worrying about that and

that would turn into I would try and stop thinking about that

so I would start thinking about something else and then

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it would just you know a big cycle and that only happens when I am depressed when I’m in a depression

Me: You can’t shut your mind off

OM: Yeah just it doesn’t for anything you know and uh---
I don’t know that doesn’t cause the depression but I know it stops me from sleeping and because I’m depressed I can’t shut my mind off at night but it’s not every night it happens you know it’s just and they’ve tried putting me on sleeping pills and medication and stuff so that I can sleep when I’m depressed because you know they say a good night’s sleep and you’ll feel better in the morning kind of thing and uh all the stuff they’ve ever given me they’ve had bad side effects on me which there in itself brings on another depression in a way like it adds to the depression because anything that the professionals do doesn’t work anyway you know and uh so finally I just gave up---but I know for a long time I had a bad problem with drinking and drugs because of the depression or---yeah I guess it was because of the depression um---it’s not what made me depressed but like I went for two years of non stop drinking other than when I was at work you know when I got up in the morning and went to work I did my job I came home I had dinner and then I went to the bar and it was like that almost every night of the week and uh---that was the only time that I ever remember ever feeling really good about myself and ---I guess it was because I was at a place where I didn’t have to care you know what I mean you know you’re in such a state that well you know um---I lost total track of what I was---

Me: So how do you deal with the depression now?

OM: Well right now I’m on what is called mood stabilizers um because antidepressants all the ones that I’ve tried so far have had bad effects on me um---it it all depends on what state of the depression I’m in when I catch it and if I catch it before um---then obviously I go to my doctors and start the process but if I’m already in the depression the last couple of times I’ve ended up in the hospital um no suicide though I’m going in and saying hey I don’t feel safe and stuff um---
Me: How can you tell it's coming on?

M: I notice that I stop caring that's the big one and that that's the main thing for me when I get depressed literally I just don't care anymore about anything and anybody like um I noticed this last time I was picking fights with boyfriend a lot um over anything and everything and I'm still doing it I'm still in the depression right now and starting to feel myself come out of it I'm starting to feel better I don't know if it's because of the medication I'm on or if it's because I'm in the counselling and have been doing the counselling for a little while and I'm starting to realize that I'm ok kind of thing----

Me: So another thing is that you get pretty irritable

M: Oh yeah oh yeah very uh and I wear it I don't just feel it I wear it and I don't care who knows I've thrown temper tantrums quite literally yelling and screaming and stamping my feet and my arms flinging in the air um---when I'm in a depression cause I'm like I don't care you know and stuff and uh I do I get really irritable and stuff and uh --- I get really irritable the littelest things set me off um--- and I guess when I was younger um when I got irritable I stayed with it and that's when I got the anger cause I was angry thank you and uh--- that that was a big thing for me anger

Me: Was there a stigma attached to depression for you? Like some how it's okay to be angry

M: Yeah yeah that that was a big thing um---um it was okay--- when you when you're angry your you feel strong you feel like you have this power but when your depressed you're vulnerable you feel like anybody can hurt you at any time it's safer to be angry now I'm realizing that you're allowed to be angry it's ok to be angry ---but that's not the only emotion that's inside you and that that's ok that not everyone's going to walk on you just cause you're feeling sad you know
802Me: So how would you like people to be with you when you start to feel sad or depressed? What would be helpful?

804M: ---I guess it would really depend on who it was um---
cause each person in my life that’s close to me I can pick out different things you know
like my mom she uh --- she supports me but when I get depressed or have a crisis it’s---it’s almost like she’s the one having a crisis um

810Me: She takes it on

811M: yeah too much you know where there’s sometimes that you just need somebody there to listen just don’t say anything just be there and it’s really hard because I know she can’t and uh—I mean I understand she’s been hurt a lot in her lifetime too and stuff she hasn’t dealt with it she has some you know but I realize there’s still issues and stuff that she needs to deal with and um me being upset or depressed triggers those um I know that but it’s still really hard I wish I wish that she could just be there for me sometimes my aunt I don’t think that there’s I wish I wish sometimes when I’m just blowing off steam that she would just listen because sometimes she does get really opinionated which is hard for me because then that makes me feel worse sometimes um but she---has always supported me 100% you know like---she she has just always always been there I mean I could phone her at anytime of the day and know that she’ll listen ---um---so there’s nothing that I would change about that really --- I mean everybody has opinions so--- um I just wish that---I I guess in some ways it was easier for me to say no to her um because she’s done so much for me in some ways I feel almost obligated to never say no which is is really difficult it’s really draining you know feeling like you have to be everything to somebody even though I know that that’s not what she expects of me but that’s the way I feel I feel like I always have to until I get into a depression and then I don’t I know I don’t have to because I know she doesn’t expect it then um--- I just---I wish for myself it wouldn’t go into a depression I just wish that I could like which I realize there’s a lot of people who do deal with depression and that are in depressions but I hate feeling this way
and it’s not it’s not when I’m in a depression I’m not necessarily negative towards myself like it’s not I’m a bad person its life you know it’s everything around me I just stop caring and I wish I don’t like that you know because it affects everything and I just—and I’m scared of people thinking it’s just an excuse you know cause it’s not cause I would give anything in the world not to feel depressed but I know my reasons like I know---it partly has to do with my history I also know that it’s family related my grandpa has been on antidepressants since the 60’s and that one of my uncles is now on antidepressants um my mom has been there and my brother has been there you know like I know it’s not just me but it still I think why me --- it uh it’s not fair

Me: So what do you think would be helpful to women, depressed women like in terms of supports or services or resources?

M: ---Oh God wow oh wow um---there’s more uh accessability or or easier to access cause I know there’s a lot of groups out there I know that there’s a lot of things out there I personally think it should be covered by medical cause there’s quite a bit of stuff out there that isn’t um

Me: Yeah like psychiatrists are covered but psychologists aren’t

M: Yeah you know like um my therapist I was lucky mine was covered through WCB but I had to go through a lot of hassle of uh I had to be the one to set it all up which when you’re in a depression your not going to you know that was when I got out of the hospital three years ago that was one of my my—I can’t think of the word there’s certain things that I had to do before they released me and one of them was to set up a counsellor um and a safe place to live that’s that’s one thing too is a---um---I know they have shelters for like battered women and stuff like that and uh I wish they had somewhere to go not in the hospital not in that kind of setting your depressed or dealing with a crisis in your life that you don’t have to go to the hospital because a lot of people put a stigma on that you know um yeah depression is what they consider a sickness but I don’t think a psychiatric unit in a hospital necessarily is the right place for everybody to be when they’re depressed you know
There's no cure to it. I think society needs to realize that it's not an evil thing to be depressed that you need to get rid of the social stigma. That there's something wrong mentally with everybody whose depressed and if they're depressed there's a reason they're depressed so let's figure out what you know.

Me: Yes they can be pretty depressing places by themselves.

M: Yeah it just you know when I was in last week they didn't rush me out but they did because the psychiatrist that I was seeing in there didn't want me to get pulled under more you know and knowing that if the professionals know that and why don't they do something about it have a place where there's more freedom like in the hospital it's so regulated you have to be up at 7:30 um--you know it just you know like to me a place to go would just be so much easier for a lot of women um because there wouldn't be the stigma.

Me: Like a group home with some structure, some support.

M: Yeah yeah, with the supports there I mean to me being allowed to cook your own meals you know being but having somebody there with you supporting you um I know it sounds silly to some people maybe but ---because I've been depressed so long or so often for so long um I don't even know how to cook properly like I didn't care for so long and now it's to the point where we don't eat home cooked meals anymore we haven't had a home cooked meal unless we go somewhere to family or something in I'd say about four months you know and---just being able to go somewhere even if you accomplish something little like cooking your own meal it's a big thing when you're depressed it's---

Me: Yes, and it's recognized.

M: Yeah you know like there's so many rules and regulations in the hospital that when you're depressed and you see somebody that could be on the same unit for a totally different reason or whatever it just it pulls you down because you start thinking oh my God I'm in a psychiatry unit and there's gotta be major problems with me and it's something with depression like yeah there is something wrong with you but there's still
life you know whereas when you’re in the unit you don’t see
that like you have to have permission to do anything you know
like I mean I can understand if you’re suicidal and depressed
yeah ok the hospital I think is the right place for you to be
because you’re not safe but if you you’re just in a depression
and you just need support the hospital I don’t think is the
right place I really don’t—and I I have uh—I’ve been I uh
I’ve been wanting to I don’t even know who to go to
I talked to my doctor about this and uh—some of the nurses
that run the day program and stuff and I brought it up and
they think it’s a good idea too but there should be um
for any medical reason not necessarily just depression but for
any medical reason something a gym like medically set up
I don’t know how to explain it I know in my head you know
what I mean I know when I’m depressed that it might take
a lot for me to actually do exercise but I always feel better
when I’m done cause like I feel the result physically and
emotionally I know I’m doing something good know what I
mean um—and plus too a lot of people I shouldn’t say a lot
of people I know for myself when I’m in a depression I can’t
work um which so then I don’t get any physical activity none
and you know and just knowing that there’s somewhere that
you can go and not have to worry cause if you’re not working
then financially you’re hurting cause even if you are on UI or
social services or whatever is helping you out your still your
not gonna be as financially stable as you were if you were
working full time kind of thing so you can’t afford you know
and stuff like that I mean I’m not saying like this big elaborate
gym like 10 treadmills and stuff like that something where you
can just go and covered by medical like like you have to have
a doctor’s referral to go there even if it’s a weight reason
medically you have to lose weight or you know like you’re in
a depression and physically you need to be doing something
or stuff like that um I think that would help a lot of people um
---the government could be doing more I feel um to help
support people that can’t work because of it I know when I
go into social services I get the run around and then I have
anxiety attacks or panic attacks as I call them I don’t like I
don’t freak out in panic I go numb I just shut off to the world
kind of thing and that’s really difficult when I’m out in public
you know like make I mean I don’t know what they can do
but make it easier for people that are on medical for depression
or for anxiety or for whatever to get the social help or the
social assistance or whatever it is that they need I personally believe that I’ve been waiting 5 weeks for my UI now and in the beginning they told me 2 weeks because it was medical you know and every week that I go in there they tell me something different like and now I find out like I got Social Services to help me until my UI comes in and now I’m finding out they’re going to take off whatever they gave me from Social Services off my UI well I relaize that the government can’t be just handing out money to people I fully understand that but they’re not doing me any favors by doing that because now I’m going to be stuck for a month again without any money and if I go to them again they’re just going to keep doing that which is just going to keep you know you fall further behind that way you know and uh---they need more safety nets is I guess what I’m trying to say or the government needs to realize that they’re just not doing enough you know like when you go into Social Services they treat everybody like I my experience anyway no matter what the reason that you’re going on Social Services for you’re garbage they uh---and that is just so degrading and when you’re in a depression or anything like that that’s just the worst feeling in the world having to beg for money having to beg for your rent to be paid having to beg to have food you know is just so degrading and it just makes you feel so much worse you know and I’ve grown up on the system I’ve grown up on welfare you know and you know having to stand in line for food banks begging for food and stuff like that is just it doesn’t help

Me: It’s so degrading and it doesn’t help when you’re depressed to have to go and deal with any of that

M: yeah you finally get okay I’m going to do this I’m going to go out I’m finally going to do something for myself that’s positive and you get there and you sit there for an hour waiting for your appointment that was supposed to start 45 minutes ago and by the time you get in there all your steam has gone and all your will to okay this is what I need is gone and then they turn around you know and they tell you one thing and then something totally different happens you know like they need the government like I say I know I keep putting it on the government but I think they have a lot of responsibility you know like you know everybody eventually is a tax payer but they make it really really hard to
Me: Like it’s not a right it’s an ok we’ll do this for you and not that it’s your right to have a standard of living and be able to afford to live somewhere

M: Like they gave us for two people to live on for a month including rent and hydro and phone maybe $789 it’s gone they gave us a cheque like a week ago and it’s gone and you know what am I supposed to do now you know not that I’m expecting hand outs you know but — I medically can’t work for whatever reason my reason is depression and I’m starting to feel better about myself so I know I’ll be able to go back maybe like they gave me six months off to to to deal with everything up to six months off and I’m starting to feel like I won’t necessarily need the six months you know what I mean but they aren’t helping at all like I have a job to go back to and stuff but like I say they’re just making it more difficult— it decreases the self worth or the feeling of self worth you know which maybe they don’t understand my big thing whenever I have a problem in the social services is just go in and say hey I have a job to go back to but right now you have a job you know where your food’s coming from you know where your pay cheque’s coming from I don’t I mean I had the choice I could have stayed at work and just kept plugging through you know doing it kind of thing but that’s not fair to my employers and to the person I work with you know um so I don’t have a choice you know why are you making this harder for me and it’s just getting me down even more

Me: So less stigma for needing assistance, for the government to make it easier, and to have programs

M: Yeah I mean I’m not talking about making it easier for anybody like Joe Blow just doesn’t want to work any more and lets go on welfare kind of thing I’m talking about people that need it you know I have a friend um when I was on medical leave from work a few years ago um um I had more problems getting my cheque each month than my friend that was living at home her parents lied about her paying room and board she just didn’t want to work and I know this for a fact in fact I’m the one that eventually ratted her out because I was just sick of it you know like she was getting cheques every month and I had
to fight for mine every time like I like working generally speaking I enjoy working I that's the one time that I feel that I'm actually doing something to serve a purpose like when I can't work because I feel so crappy about myself that makes me feel even worse and then when I have to beg to live when I'm already feeling crappy about life what's the point but I mean I understand that they make the rules for one then it's not fair to all but

Me: Maybe to look at individual circumstances.
Well you've come up with some really good ideas Is there any questions that I didn't ask you or something you really want to add or say?

---that---depression---is something that a lot of people have to live with and maybe a lot of people don't recognize that they're in a depression um---but just because we're depressed doesn't mean we're not people you know you get a lot of stigmas attached to it that makes it even harder to deal with depression more awareness I guess a lot more I mean people now are finally starting to realize that that it's in the society that this happens um---but more support and more awareness