DIMENSIONS OF POWER:
OLDER WOMEN'S EXPERIENCES WITH
DEPRESSION AND ELECTROCONVULSIVE THERAPY

by

ALISON L. ORR

B.A., The University of British Columbia, 1987
B.S.W., The University of British Columbia, 2000

THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF SOCIAL WORK

in

THE FACULTY OF GRADUATE STUDIES
School of Social Work and Family Studies

We accept this thesis as conforming
to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA
SEPTEMBER, 2001

© Alison L. Orr, 2001
In presenting this thesis in partial fulfilment of the requirements for an advanced degree at the University of British Columbia, I agree that the Library shall make it freely available for reference and study. I further agree that permission for extensive copying of this thesis for scholarly purposes may be granted by the head of my department or by his or her representatives. It is understood that copying or publication of this thesis for financial gain shall not be allowed without my written permission.

School
Department of Family Studies & Social Work.

The University of British Columbia
Vancouver, Canada

Date Sept. 25/01
ABSTRACT

This research explored how women over the age of 65 have wholistically experienced depression and receiving electroconvulsive therapy (ECT) as a treatment for their depression. Women's voices were gathered through in-depth, face-to-face, semi-structured interviews with six participants between the ages of 71 and 89 who had been diagnosed with depression and received ECT. The qualitative analysis revealed that these women's experiences could be described as a four-part journey. The four stages of their experiences were: becoming depressed, conditions of getting help, the treatment, and the hope for recovery. Across each of these stages of the women's experiences, the theme of power and its many dimensions played a predominant role. Relevant dimensions of power identified were: the power of the depression, lack of power due to multiple losses, structural inequities, and gender socialization, and the power held by healthcare professionals in the lives of these women. The findings from this study hold specific implications for the process of informed consent, and the necessity of including women's voices and alternative models of understanding in healthcare policy-making, program development and service delivery. Recommendations for change come by way of feminist theory and empowerment-oriented social work practice with older adult women.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>ii</td>
</tr>
<tr>
<td>TABLE OF CONTENTS</td>
<td>iii</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>v</td>
</tr>
<tr>
<td>DEDICATION</td>
<td>vi</td>
</tr>
<tr>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>CHAPTER ONE - CONCEPTUAL CONTEXT</td>
<td>5</td>
</tr>
<tr>
<td>Dominant View of Aging and Depression:</td>
<td>5</td>
</tr>
<tr>
<td>the Biomedical Perspective</td>
<td></td>
</tr>
<tr>
<td>A Feminist Critique and Alternative View</td>
<td>9</td>
</tr>
<tr>
<td>The Lives of Older Women</td>
<td>9</td>
</tr>
<tr>
<td>Medicalized Care and its Implications</td>
<td>10</td>
</tr>
<tr>
<td>A Feminist View of Depression</td>
<td>13</td>
</tr>
<tr>
<td>An Overview of ECT Literature</td>
<td>18</td>
</tr>
<tr>
<td>The Impact of ECT</td>
<td>18</td>
</tr>
<tr>
<td>The Wholistic Experience of ECT</td>
<td>23</td>
</tr>
<tr>
<td>Purpose of the Study</td>
<td>24</td>
</tr>
<tr>
<td>CHAPTER TWO - METHODOLOGY</td>
<td>28</td>
</tr>
<tr>
<td>Rationale</td>
<td>28</td>
</tr>
<tr>
<td>Theoretical Perspectives</td>
<td>29</td>
</tr>
<tr>
<td>Hermeneutics</td>
<td>29</td>
</tr>
<tr>
<td>Feminism</td>
<td>31</td>
</tr>
<tr>
<td>Post-Modernism</td>
<td>33</td>
</tr>
<tr>
<td>The Research Process</td>
<td>35</td>
</tr>
<tr>
<td>Locating Participants</td>
<td>35</td>
</tr>
<tr>
<td>Participant Profiles</td>
<td>37</td>
</tr>
<tr>
<td>Interview Process</td>
<td>41</td>
</tr>
<tr>
<td>Data Analysis</td>
<td>46</td>
</tr>
<tr>
<td>Credibility</td>
<td>51</td>
</tr>
<tr>
<td>Summary</td>
<td>52</td>
</tr>
<tr>
<td>CHAPTER THREE - FINDINGS</td>
<td>54</td>
</tr>
<tr>
<td>The Invasion</td>
<td>54</td>
</tr>
<tr>
<td>Unexpected Event</td>
<td>54</td>
</tr>
<tr>
<td>Outside Entity</td>
<td>58</td>
</tr>
</tbody>
</table>
CHAPTER FOUR - UNDERSTANDING AND INCORPORATING THE EXPERIENCES OF OLDER WOMEN

Dimensions of Power
The Trust and Power Granted to the Medical Profession
Is Informed Consent Truly Voluntary?
The Disconnected Self
Medicalized Emotions and Experience
Implications for Change
Feminist Theory
Empowerment-Oriented Social Work Practice
Practical Applications
Alternative Informed Consent Process

CONCLUSION

BIBLIOGRAPHY

APPENDIX A: ETHICS APPROVAL CERTIFICATE
APPENDIX B: VRHB APPROVAL LETTER
APPENDIX C: AGENCY APPROVAL LETTER (GPOT)
APPENDIX D: PARTICIPANT RECRUITMENT NOTICE
APPENDIX D: PARTICIPANT CONSENT FORM
APPENDIX F: INTERVIEW GUIDE
I would first like to thank the 6 women who participated in this research project. Without their courage, openness and willingness to participate, this project would not have been possible. A particularly gracious thanks goes to my faculty advisor Dr. Deborah O'Connor whose guidance, patience and encouragement has been invaluable in completing this project. I would also like to thank my other committee members Dr. Margaret Wright and Linda Tod whose considerable time spent reviewing this document and valuable feedback was well appreciated. Another acknowledgement extends to the members of the Geriatric Psychiatry Outreach Team at Vancouver Hospital for all their support and assistance with my research, as well as to the geriatric mental health team members who assisted me with finding participants.

I must not forget to thank my partner Maureen Edgar who has been a constant source of support and encouragement through many frustrating moments and frequent long nights. I would also like to thank the B.C. Medical Services Foundation for the financial support in the form of a summer research scholarship.
DEDICATION

As promised to my friend, surrogate mom and mentor Shari Craig, two and a half years ago as she was dying of cancer, this thesis is dedicated to her. Shari was a woman who worked for many years with older adults in the areas of promoting better home healthcare, senior's networking, educating awareness of elder abuse and hospice care. She was the one who originally inspired and fostered my work in the field of aging and advocacy for older adults. She believed in me, allowed me the professional opportunities to challenge and prove myself and encouraged me to pursue higher goals. She will not be forgotten.
INTRODUCTION

Depression is one of the most widely studied mental illnesses, yet our understanding of depression and treatment is still incomplete (Schreiber, 1996; Steen, 1991). An estimated 10-25 percent of North American women will experience an episode of depression in their lifetimes (Clarke Institute, 2000; Steen, 1991). According to Statistics Canada (1996) and the Clark Institute of Psychiatry (2000), Canadian women are statistically over-represented and are cited as suffering from depression at two to three times the rate of men. These figures show a large gender differential. It is believed that over the age of 65, all adults becoming vulnerable to experiencing depression for a variety of reasons such as chronic illness, declining abilities and multiple losses (Koenig, 1999). For older women, the rate of depression does not change from that of women overall (APA, 1996; Wykle & Musil, 1993); however, the instance of depression in acute or long term care facilities, which are a predominantly female population, is said to be as high as 37 percent (APA, 1996).

Electroconvulsive therapy (ECT) has been touted as "the most effective treatment available in psychiatry" for treating depression (Harrigan, 1999, p. 1). ECT refers to the modern procedure of inducing an epileptic type seizure in the brain through either unilateral or bilateral electrode placement to the temples of the head (Abrams, 1997; Fink, 1999). ECT has always been a highly controversial treatment process. This is primarily due to the treatment's rather extensive and tumultuous early history of misuse and harmful side effects such as severe convulsions, memory loss, bone breakage and even death (CCHR, 1997; Kelly & Zisselman, 2000; Smith, 2001). This was particularly the case prior to the use of anaesthesia and muscle paralysis agents during the process (Abrams, 1997; APA, 1978/96).
ECT's primary therapeutic purpose currently is in the treatment of affective disorders, particularly major depression (Abrams, 1997; Fink, 1999). The elderly as a group have the highest rates of treatment for depression through the use of ECT (Butler & Cohen, 1997; Kelly & Zisselman, 2000; Larkin, 1993; McCartney, 2000), with older women being the most likely to be treated for depression with ECT (CCHR, 1997; Kelly & Zisselman, 2000). More than double the number of women are treated with ECT as compared to men (Breggin, 1979; Cancelliere, 1998; In Brief, 1999; Kelly & Zisselman, 2000). The use of ECT among older individuals is increasing according to statistics for Riverview Hospital where the use of ECT in its geriatric psychiatry program has more than doubled in four years from 678 treatments in 1996 to 1558 ECT treatments administered in 1999 (Fayerman, 2000). This is a very current and relevant topic then for older women, geriatric psychiatry, continuing care providers and anyone who has older female adult loved ones. Despite current research done on ECT's physical and cognitive effects, very little attention has been paid to how individuals actually experience receiving ECT and how it may impact their life (Abrams, 1997; Johnstone, 1999).

My interest in this topic arose from a combination of experiences. For the past nine years I have worked in a variety of community and facility health care settings primarily with older adults. Both professionally and personally I have dealt with many older women who have been diagnosed with depression and a number who have been treated with ECT. I also have a close aunt who has received ECT for depression. The use of ECT and all of its controversies intrigued me but not necessarily from the point of view of whether it was right or wrong, or whether to prove or disprove its efficacy. I became more interested in what issues underlie this type of treatment, since most of the older women I had known to have ECT agreed to have it despite extreme reluctance and fear. My supposition from the very beginning was a rejection of
the dominant ideologies that seemed to form the basis of research into both depression in
women and ECT use. Both seem to take on a rather essentialist view which fails to look past
dominant ideology. I wanted to transcend this view by developing a different understanding
from the perspective of older women.

In order to examine the issue I turned first to the literature. Prevailing literature on both
depression in older women and ECT tend to be primarily positivistic and biomedical in nature.
Very limited literature exists on the experiences of older women with depression and virtually
no literature discussed the experiences of older women with ECT. Given the increasing number
of older women in society, and in both the healthcare and mental health systems, the need to
include their voices in the research on areas that affect them directly is apparent.

The aim of this research project, was to explore how women over the age of 65 made sense
of their experiences with depression and ECT as well as illuminate the necessity of including
women's wholistic experiences in the healthcare system. To address these purposes, I
interviewed six women over the age of 65 who had been diagnosed with depression and
received ECT for it. Semi-structured interviews were conducted in participant's homes and
focused on understanding their thoughts and feelings regarding their depression and ECT
treatment. Follow-up interviews were employed as a method of data verification and accessing
more information. A combination of individual case analysis, discourse analysis and thematic
categorization was used to analyze the data.

This thesis, the culmination of the research project, is organized in the following manner.
Chapter one provides the foundation for the study. An examination of literature regarding the
dominant biomedical view of depression and treatment, a feminist alternative view and an
overview of ECT research will be presented. The chapter will end by outlining the purposes and rationale for this type of research study.

Chapter two outlines the research methodology employed. It provides a general discussion of the theoretical positions of hermeneutics, feminism and post-modernism which informed the research process. The chapter further details the research design such as the recruitment of participants, participant profiles, the interview process, data analysis, and the tests for credibility.

Chapter three presents the findings of the study. This section details the four-part journey of the participants and highlight the themes and discourse that emerged through their stories.

Chapter four examines in more detail the dominant theme of power and how it plays out throughout the course of the participants' experiences. This chapter will reveal how these findings compliment and diverge from existing knowledge in the area of healthcare, mental health care and older women. Implications for social work practice are also addressed.

To me, this study highlighted the influence of the various dimensions of power including gender socialization for this age group, structural inequities, multiple losses, the biomedical model and the resulting vulnerability of older women within this type of system. The importance of including the component of experience in the healthcare process is essential. "It is through women's own voices that a different and more accurate picture of women's health is emerging... Voicing gives visibility to an issue: the word is flesh" (Hajdukowski-Ahmed, Denton, O'Connor & Zeytinoglu, 1999, p.39)
CHAPTER 1
CONCEPTUAL CONTEXT

As a foundation for the research project undertaken, this chapter will explore the multiple ways of understanding the issue of depression and its treatment in older women. First, the biomedical model as the pre-dominant view of depression and treatment, particularly as it relates to older women, will be discussed. Second, a feminist critique of this model and an alternate view of depression and the lives of older women will be presented. Third, an overview of ECT research will be provided with gaps in the research noted. Finally, the purpose, goals and rationale of this research project will be detailed.

Dominant Views of Aging and Depression: The Biomedical Perspective

The development of the market economy has had a dramatic influence upon the field of medicine and the rise of the biomedical model (Longino, 1997). Along with advancing technology came advancements within the field of health. Expanding knowledge and technology meant new medications and procedures that contributed to better living conditions and extended life expectancy (Maddox, Atchley, Poon, Roth, Siegler, Steinberg & Corsini, 1987). The discovery of bacteria and the development of the germ theory of disease had a profound impact on the practice of medicine (Bolaria, 1988). What arose from this paradigm was a mechanistic view of the human body with treatment being focused on restoring normal functioning (Bolaria, 1988; Estes & Binney, 1989). This ideology forms the basis of the biomedical model.

The existing paradigm of modern scientific medicine may be called the Western biomedical model. It relies on an essentially mechanical understanding of causation, one derived from science. Repairing a body, in this view, is analogous to fixing a machine (Longino, 1997, p.14).
The experience of aging and the lives of older people have been profoundly impacted through the use of the biomedical model. As previously noted, the biomedical model wields significant power in how we view health, as well as aging (Estes & Binney, 1989; Longino, 1997/98). The biomedical model views aging within the context of a disease process (Grant, 1996; Longino, 1997). Aging is constructed as a medical problem with focus on diseases of the elderly. The older adult is often viewed as defective or worn out and in need of "repair" (Estes & Binney, 1989). "Equating old age with illness has encouraged society to think of aging as pathological or abnormal" (Estes & Binney, 1989, p. 588). This view has greatly impacted how we view and care for our elders and has helped give rise to a highly medicalized view of aging and economically managed care (Aronson, 1999; Neysmith & Macadam, 1999). Institutional care of the aging population has become increasingly medically focused and economically regulated with responsibility for care falling to healthcare professionals. In Canada, women make up the majority of adults over the age of 65. By the year 2016 it is estimated that women over the age of 65 will comprise 18 percent of the population (Maxwell & Oakley, 1998). Given that women make up the majority of the elderly population they are the ones most impacted by these mechanistic and reductionistic views (Longino, 1997).

The biomedical model, just as with aging, has effectively established itself even within the realms of emotional illness such as depression (Brems, 1990). Through the use of medical diagnostic tools, emotional disorders, like physical illnesses, can be simplified to a checklist of symptoms with the aim of curing usually through physically tangible means (Longino, 1997). *The Diagnostic and Statistical Manual of Mental Disorders IV-TR* (2000), is the current authoritative reference for diagnosing major depression. Within this manual, depression is reduced to a series of precise symptomatic criteria. According to the DSM-IV-TR (2000), a
A major depressive episode is defined as a period of at least two weeks where an individual has a despondent mood or loss of interest and/or pleasure in almost all activities. Accompanying this alteration in mood, the person must also exhibit at least four additional symptoms from a list that includes: changes in appetite, sleep and activity levels; decreased energy; feelings of worthlessness or guilt; problems thinking clearly, concentrating or making decisions; or recurrent thoughts of death, suicide or actual suicide plans or attempts. A major depressive disorder is diagnosed on the basis of one or more of the above described major depressive episodes occurring within a two month period, without being accounted for by other disorders such as schizophrenia, dementia, other mood or psychotic disorders or substance abuse to name a few (APA, 2000). The DSM-IV-TR goes on to discuss factors associated with the onset of major depressive disorder and cites precedents such as, medical illness, gender and age risk factors, familial pattern and connection with other emotional disorders. Emotional illnesses such as depression, like aging, within the biomedical paradigm become equated with physically, tangible illness and therefore potentially curable or removable (Brems, 1990; Brown, 1994; Estes & Binney, 1989).

Depression is an illness like diabetes or asthma. It can happen to anyone. You may feel that you should be able to get out of it on your own. Don’t. The earlier you seek help, the sooner you may begin feeling like yourself again. Your doctor understands and can help (SmithKline Beecham, 2000, p. 2).

This statement from a depression inventory pamphlet clearly equates depression with a physical illness. It also places the knowledge, expertise and power to cure the individual solely in the hands of a medical professional. This reinforces the expert knowledge basis inherent in the biomedical perspective.

A biomedical paradigm also approaches explaining the rate differential in incidence of depression between men and women. Many explanations account for the differences in rates of
depression through biological or genetic variation between men and women. Biological differences such as the type and amount of hormone circulation, changes in hormone levels after child-birth or menopause, and differences in neurochemistry or genetic susceptibility are just a few of the differences cited (Brems, 1990). Through this approach, depression in women is described and treated through a biomedical model with individually focused treatments.

The treatment for such a presumed biochemical illness becomes one that is also highly medicalized, such as medication or ECT which treat symptomology only. Biologically, depression is thought to originate in the prefrontal cortex of the brain which regulates emotion (Marano, 1999). Simply put, it is believed that depressed people have a failure of the left prefrontal cortex, which results in them being unable to respond to positive stimuli thus losing motivation and being unable to experience pleasure. Medications that address this problem have changed significantly over the years, with each focused on increasing different neurochemicals within the brain with the hope of elevating mood inhibitors (Williams, Mulrow, Chiquette, Noel, Aguilar, Cornell, 2000). Two of the newest and most widely used class of anti-depressant medications are the selective serotonin reuptake inhibitors (SSRIs) and the serotonin and noradrenaline reuptake inhibitors. These anti-depressants work by blocking the noradrenaline and/or serotonin receptor sites in the brain thereby increasing the level of these neurochemicals and stimulating the left prefrontal cortex (Breggin & Cohen, 1999; Marano, 1999). Examples of such anti-depressant medication are Prozac, Paxil, Celexa, Effexor and Remeron to name a few (Williams et al., 2000). ECT is another mode of treatment used for depression and will be discussed in detail further along in this chapter. In the case of ECT as a treatment for depression, the mechanism of action is not well understood (APA, 1996; Fink, 1999).
The biomedical paradigm then, reduces aging and depression to a physically/biologically tangible etiology rendering both potentially curable through treatment. The woman's individuality, thoughts and interactions with her environment are unaccounted for in this model.

A Feminist Critique and Alternative View

Whereas a biomedical view may remove the personal life of the older woman from the diagnosing and treating of depression, a feminist model seeks to understand and incorporate the individual experience, gender socialization and structural implications into the discussion (Flax, 1997).

The Lives of Older Women

One critique of the biomedical model is that it overlooks the impact of gender socialization. The context of older women's lives should not be overlooked when trying to understand their perspective and interactions with the healthcare system (Cox & Parsons, 1996). All women over the age of 65 today have lived through at least one World War, the Depression, the Cold War, the Women's Movement, and innumerable technological changes. The specific impact of such life altering events is immeasurable but undoubtedly leave their mark. For example, all women over 65 have seen significant medical advancements throughout their lifetime that, as previously suggested, gave rise to the biomedical perspective. These medical developments have saved countless lives and included more extensive research on diseases and cures for illnesses through new medications and surgery. Thus many older women today often view the medical profession with a great deal of respect and unquestioning authority (Beisecker, 1996).

Gender socialization also plays an influential role in the lives of all women but particularly older women. Women over the age of 65 grew up in a pre-Women's Movement era of the early to mid 1900's, where the societal messages for women were loud and clear and reinforced
through every media source available. Women were expected to take care of their appearance so that they were appealing to men; mistrust and compete with other women for the affections of men; be good wives/mothers and take care of the families' needs; be cooperative; and put up with difficulties without complaint or discussion (Huggan, 2001). Any failure to live up to these expectations, or audacity to challenge these requisite behaviours was seen as a failure. The role this early gender socialization played in the lives of older women is undeniable and should not be minimized when trying to gain an understanding of not only the development of depression in older women, but also their interaction with the healthcare system in seeking treatment.

Medicalized Care and its Implications

A second critique of the dominant biomedical paradigm is that it can lead to a highly medicalized view and treatment of both aging and depression (Brems, 1990; Estes & Binney, 1989). The problem with this restrictive perspective is that it is grounded in the assumption that depression is purely a biological illness. This perspective can facilitate detaching depression from life experiences and structural factors which may contribute to incidence of depression in older women (Brems, 1990; Schreiber, 1996). What has resulted from this, as has been alluded to, is the treatment of older women with depression in a way that often denies the women's life histories and personhood and situates healthcare professionals as being the experts in charge of the women's care (Aronson, 1999; Estes & Binney, 1989). The implications of this type of medicalized care of older women are substantial and far-reaching.

"As I think about aging, I realize that I have not yet begun to suffer from the general contempt for older women and from a sense of my invisibility" (Meigs, 1990, p.172). One implications is that a highly medicalized view of aging can contribute to ageism. Ageism is the
biased and negative expression of attitudes about the process of growing older (Kaufman, 1993). The elderly and particularly elderly women in our society are not accrued the status or positioning they may have in other cultures (Grant, 1996). "Society's attitudes and beliefs about aging are culturally embedded and can have a profound effect on how people view themselves and others who are aging" (Grant, 1996, p.9). There are many myths and stereotypes about aging. Some examples of such beliefs are that the elderly are disabled, cognitively impaired, asexual and that the elderly lead meaningless and inactive lives (Cox & Parsons, 1994).

It is in the field of healthcare where the impact of ageism and the devaluing of older women's lives is most pronounced (Aronson, 2000; Hajdukowski-Ahmed et al., 1999). Ageism can be seen as both a precursor to and result of this type of care model. On one hand, ageism has influenced the creation of medicalized care of elders through the association of aging with disease (Estes & Binney, 1989). On the other hand, ageism can by recreated through the process of medicalized care. Since a highly medicalized care model is the norm for elder care, the public gets the reinforced message that illness is equated with aging and these myths are perpetuated. The impact of such biased and disrespectful treatment by society and the healthcare system is twofold. One impact is that it fosters a sense of helplessness in the elderly thus leading to increased dependency, despondency and an increase in physical and mental illness (Grant, 1996). The second result is that this treatment reinforces the stereotypical and inferior position of elderly women in society and thus perpetuates the cycle of marginalization (Minichiello, Browne & Kendig, 2000).

A second implication of an over-medicalized view of aging is how it has influenced healthcare restructuring, with a view towards fiscal management, and the impact that has had on the lives and care of older women.
In their preoccupation with deficit reduction and limiting social spending, federal and provincial governments in Canada are, increasingly, replacing traditional approaches to the organization of public health and social care with models of corporate management that promises efficiency and cost-saving (Aronson, 1999, p.49).

The language of healthcare, as well as the nature of care itself, has significantly changed as a result of these economic measures that have arisen through a medicalized view of aging (Aronson, 1999; Neysmith & Macadam, 1999). Older adults are labelled as over users of the health care system (Beisecker, 1996) and subsequently have become the primary focus of restrictive economic measures (Aronson, 1999). "The medicalization of old age in the late twentieth century means that the administrative practices of long-term care policy are important influences on the quality of life of women" (Neysmith & Macadam, 1999). Not only does this model often utilize practices of non-inclusive client decision making in service delivery, but the language used in the delivery of care services to older adults is depersonalized and marginalizing (Aronson, 1999). Older adults of whom the majority are women become "case managed" rather than cared for. So the medically driven and economically managed model of care currently utilized, further reinforces the subjugated role of elders and denies them assistance which focuses on their individuality and goals rather than potential health issues.

A third implication of medicalized aging and care is the power the physicians and medical personnel have in the lives of older adults and particularly older women. As previously, noted, the biomedical model situates the healthcare professional as the expert in the delivery of care. "There is a widespread belief that doctors are the 'real' experts on women's health and that biomedicine holds the key to improving it" (Doyal, 1995, p.1). Doctors play a very large and influential role in the lives of older women (Beisecker, 1996; Grant, 1996). Elderly women due to a number of factors such as gender role socialization, learned respect of health authorities and
life issues and circumstances, are not as likely as younger individuals to ask questions and take
an active role in health care decision making (Beisecker, 1996; Minichiello et al., 2000; Ryan,
Meredith, Maclean & Orange., 1995). Elderly women are often treated condescendingly, given
cursory information, and are often treated as if they are unable to understand or consent to
treatments (Beisecker, 1996). It has not been uncommon for these women to be discouraged
from or denied participation in health care decision making (Beisecker, 1996; Breeding, 2000).
Research has found quite consistently that doctors prefer compliant, agreeable patients
(Beisecker, 1996; Putnam, 1996). Unfortunately, the impact of such unquestioning compliance
is negative and has been found to foster a sense of helplessness in older women thus leading to
increased despondency and an increase in physical and mental illness (Doyal, 1995; Grant,
1996). This can serve to create greater dependency on health care resources by older adults
(Beisecker, 1996).

A Feminist Look at Depression in Older Women

An alternate view of depression is one supported through feminist theory. "One goal of a
feminist constructionist science is 'disrupting and displacing dominant (oppressive) knowledges
in part by articulating the values supported by alternate conceptions of reality" (Riger, 1992,
p.735). Although the same despondent mood, lack of interest and motivation identified by the
DSM-IV-TR (2000) as signs of depression may be similarly viewed as depression within a
feminist perspective, an explicit, criteria based definition of depression is not utilized by
feminist theory. Feminism may also view the etiology of depression as being quite different.
Instead, feminist theory recognizes that individuals will naturally experience a wide range of
emotions, which in a healthy state, are integrated into their personality and have a natural mode
of expression (Schreiber, 1996). Feminism also acknowledges the often gender based,
differential sanctioning of various emotional expressions within Western cultures (Jaggar, 1997). For example, it is still deemed inappropriate for men to cry openly, yet women are allowed to, however, there is a price to pay for this freedom. Women are seen to be the bearers of emotion and because of this are deemed unpredictable and irrational and are often forced to quell emotions to seek legitimacy (Jaggar, 1997). The accepted external emotional life in Western cultures then seems to be one of bland passivity (Jaggar, 1997). The expressions of depressive type behaviours tend to be unacceptable in all cases. Feminism encourages research into challenging these sanctions and conceptions of reality such as with the one-dimensional view of depression (Jaggar, 1997). This is not to say that a feminist perspective in all cases rejects a biochemical basis of depression. Instead, feminism seeks a more inclusive perspective which incorporates the biochemical when appropriate and advocates for the recognition of the often disregarded, circumstantial and structural factors that affect women's emotional states (Brems, 1990). Essential to achieving this is an understanding of how gender, age, class and race oppression intersect and impact women's lives.

A gender analysis is critical to the understanding of this issue for there is what could be termed a feminization of depression occurring. As an alternative to the biological explanations, it could be said that structurally in society, women have a lot to be depressed about. Poverty rates amongst single women and particularly single women with children is on the increase and accounts for the highest proportion of people living in poverty in North America (NAPO, 1998). Domestic violence is widespread. The incidence of spousal abuse alone is conservatively estimated at one to two in ten wives (Taylor, 1993). From 1974-83 alone, women murdered by their husbands accounted for 41 percent of adult female homicides in Canada (Taylor, 1993). Estimates of sexual abuse indicate that 38 percent of women are sexually abused before the age
of 18 (Carter, 1993). Women also account for the majority of caregiving in society both personally and professionally (Baines, Evans, & Neysmith, 1993). This caring role is undervalued by society and sets up a gendered division of labour leaving women economically vulnerable (Baines et al., 1993). These issues when dealt with on a day to day basis have a profound impact on women's affect and behaviour and could contribute to depression (Brems, 1990).

Another way to approach the issue of women's over-representation in depression statistics is by looking at what the diagnosis of depression entails and how it is clearly biased towards diagnosing women (Brems, 1990). The DSM-IV-TR (2000), as previously noted, indicates that the criteria for depression includes such features as loss of energy, feelings of worthlessness, change in appetite, change in sleep patterns, diminished ability to concentrate, loss of interest in usual activities and suicidal ideation. Many of the diagnostic characteristics of depression represent internalized feelings and self-deprecating behaviour. Traditionally, many of these behaviours are more likely to be exhibited by women when experiencing stress and loss, thus women become diagnosed more readily (Brems, 1990). These criteria do not include some externalized emotions such as anger and related addictive behaviours that men often show as a response to stress (Brems, 1990; Butler, 1998). For example, alcoholism according to Statistics Canada, (1996) affects men at four times the rate of women for the under 65 age group and twice the rate of women for the over 65 age group. Alcoholism has been clearly linked as a risk factor for depression, particularly in the elderly (APA, 1996; Butler, 1998). Alcoholics report symptoms such as a sense of worthlessness, change in sleep patterns and loss of interests which are diagnostic criteria of depression, yet alcoholism is not used as a criteria for the diagnosis and reporting of depression (Brems, 1990; Butler, 1998). General anxiety, unassociated with
specific anxiety disorders, has also been found to be an indicator for depression, particularly in
the elderly (Lasser, Siegel, Dukoff, & Sunderland, 1998). Anxiety occurs at a more equal rate
in both men and women, but again, is not a recognized diagnostic criterion for depression by the
DSM-IV-TR (Lasser et al., 1998). Finally, it has also been proposed that women are more
willing to admit depressive symptoms and more likely to seek professional help than men are,
thus women are more readily identified and labelled as depressed (Brems, 1990). Despite this
information, men are still not being diagnosed with depression at nearly the same frequency as
women. What begins to emerge is a picture of depression that is quite different than that
portrayed by statistics and by those researching, diagnosing and treating depression.

Age is another critical element for analysis since for elderly women, the circumstances for
creating and sustaining depression are magnified. "Depression in elders may not be biologically
based but may be related to the social aspects of aging" (Cox & Parsons, 1994, p.23). Elderly
women experience significant losses in their lives: the loss of loved ones, friends, roles, homes,
losses of physical capabilities, sometimes cognitive abilities and even a loss of their freedom.
Elderly women comprise over 71 percent of the population of care facilities (Patchner &
Patchner, 1996), where the rates of depression are found to be the highest (APA, 1996). Older
women experience numerous deaths of those close to them (Cox & Parsons, 1994). By the age
of 80 years, 67 percent of married women are widowed (Martin-Mathews, 1999). Chronic pain
and debilitating illness is also a major factor in the onset of depression in the elderly (Casey,
1994). All these factors and others create a substantial impact that could leave their mark on the
emotional states of elderly women.

Class and race are yet two more important components of this discussion. The elderly and
particularly elderly women, as previously noted, are a marginalized group in society with little
power or voice to change their circumstances (Cox & Parsons, 1994). Seniors and particularly, older women are viewed within a capitalist system as being unproductive members of society and therefore undervalued and a burden to society (Minichiello et al., 2000). Poverty is also a significant issue in the lives of elderly women with an increasing number of elderly women living in poverty (NAPO, 1998). Statistics from the United States indicate that up to 40 percent of women for at least some time within the first five years after being widowed live in poverty (Martin-Mathews, 1999). By virtue of their age and fewer economic resources, elderly women may often exert little control over the direction of their lives. Thus class disenfranchisement could contribute to older women's depression through an inability to exert control over their present and future life conditions (Grant, 1996). If race is added to the equation the situation is magnified and the potential for the exploitation of elderly women is enormous. It has been readily identified that racial discrimination can lead to ill physical and mental health in individuals (Brems, 1990; Hajdukowski-Ahmed et al., 1999).

The biomedical perspective then with its mechanistic view of the body that can be repaired, tends to promote a view of aging and depression that is highly medicalized. Age becomes associated with illness and depression is addressed solely biologically with the objective of curing through medical treatment. A feminist approach to the issue of depression in older women is aimed at looking at incorporating very real life circumstances, gender socialization and structural factors into the equation. The point is to recognize and incorporate individuals experiences and acknowledge that there are alternative realities to that expressed by the biomedical paradigm.
ECT (Electroconvulsive Therapy) is a highly medicalized form of treatment for depression which is still not fully understood (Fink, 1999). ECT as a treatment can be described as follows:

Electroshock involves the attachment of electrodes to the temples outside one (unilateral) or both (bilateral) frontal lobes and the administration of electricity to the frontal lobes of the brain. Intensity of voltage may vary from approximately 70 volts to approximately 600 volts. Duration of the electrical current may vary from 0.5 to 4 seconds. Administration of ECT also varies enormously in number of treatments, from one to literally hundreds, over time. A typical course of treatment involves 6 to 12 sessions (Breeding, 2000, p. 69).

Most ECT treatments are conducted in an operating room and prior to the administration of the electric current, individuals are given a general anaeesthesia, a muscle relaxant, oxygen and a mouth guard (APA, 1996). Individuals are heart monitored throughout the procedure and their heads are either held in place by a strap or by a person (Abrams, 1997). Upon application of the electrical stimulus, an epileptic type seizure is induced in the brain of the individual (Fink, 1999). Outwardly, a pronounced clenching of the facial muscles and jaw can be observed and this is usually followed by a slight twitching of the feet that lasts between 15 and 25 seconds (Abrams, 1997). The twitching of the feet for closer to 25 seconds is a desirable outcome and indicates that a seizure threshold has been obtained, thereby signifying a therapeutic treatment level (Abrams, 1997).

The Impact of ECT

Research has looked at the impact of ECT from various angles. The rationale for ECT's predominant use on adults over the age of 75 has been explored as well as the cognitive, physical, psychological and emotional effects of ECT. A number of researchers have studied the effectiveness of ECT as a treatment for depression in the old-old or frail elderly, who have been defined by medical researchers as over 75 years of age.
age (McCartney, 2000; Tew, Mulsant, Haskett, Prudic, Thase, Crowe, Bolata, Belgley, Reynolds, & Sackheim, 2000). As previously noted, the elderly and specifically elderly women statistically show the highest rates of depression and are the population that is currently treated the most by the use of ECT (Breggin, 1979; Cancelliere, 1998; Koenig, 1999). The rationale for the high use of ECT in the elderly is threefold. First, depression in the elderly may be life threatening due to suicide risk or other health complications (Kelly & Zisselman, 2000; Koenig, 1999). Second, the elderly may not tolerate medications well or may be more susceptible to side effects. Third, the elder may be unresponsive to anti-depressant medications (Kelly & Zisselman, 2000; Koenig, 1999). Others, rather than seeing ECT as a treatment method of last resort, see it as a front-line treatment (APA, 1996; Harrigan, 1999).

There has been a significant amount of research focusing on ECT's physical and/or cognitive effects and treatment effectiveness. Information available on the physical and cognitive side effects of ECT is often inconclusive and conflicting (Breggin, 1979; CCHR, 1997; Fink, 1999; Sackheim, 1997). A number of studies suggest that any cognitive deficits, such as memory loss, resulting from ECT treatments, are only temporary effects (Abrams, 1997; Fink, 1999). The most definitive word on the cognitive impact of ECT comes via the American Psychiatric Association ECT task force in 1978 and again in 1996. This task force reported that memory loss resulting from ECT treatments are dependent on a number of variables such as the length of treatment, number of treatments, and bilateral or unilateral electrode placement, but that the cognitive changes, such as memory loss, can be permanent (APA, 1978/96; Weiner & Krystal, 1994). The cognitive impact of ECT on the elderly appears to be more widely debated as well as the long-term impact of maintenance ECT which is utilized more often with an older
population (Kelly & Zisselman, 2000; Sigler, Aizenberg, & Weizman, 1998). The necessity for further investigation in this area is indicated.

Other studies have looked at the physical effects of ECT such as the potential for bone fractures (APA, 1978/96; NIH, 1985). These studies found that the current use of anaesthesia and muscle paralysis agents has mitigated the likelihood of bone fractures or other bodily damage during treatments (APA, 1978/96; Breeding, 2000; NIH, 1985). A significant amount of research has been on conducted on the impact ECT has on the elder's physical health given the higher incidence of health concerns within this age group (Kelly & Zisselman, 2000; Koenig, 1999; Sigler et. al., 1998; Tew et. al., 2000). Research has determined that there is only a moderate risk for heart attacks and/or strokes during treatments (Breeding, 2000; Weiner & Krystal, 1994). It has been found, that the incidence of asystole (the absence of a heartbeat for 5 seconds) is quite a common occurrence during ECT, particularly in older recipients (Burd & Kettl, 1998), thus indicating that there is risk involved which is specific to older adults. Despite these physical effects, the risk and incidence of death has been determined to be quite low (Kelly & Zisselman, 2000; NIH, 1985). Recent research with older adults has generally shown a positive result in reducing depression faster through ECT than by other means, with fewer negative physical effects (Kelly & Zisselman, 2000; McCartney, 2000; Tew et. al., 2000).

Research on the cognitive and physical side effects of ECT have generally focused on supporting the efficacy of ECT as a treatment for depression, while indicating the minimal adverse effects the treatment has (APA, 1978; Harrigan, 1999). However, as noted, controversy, conflicting research and inconclusive evidence continue to fuel the debate over the potential adverse cognitive, physical and physiological side effects of ECT, which generates more research (Breggin, 1979; Breggin, 1997; Eastgate, 1998; Harrigan, 1999; Stevens, 1999).
Interestingly, early researchers, mainly psychoanalytic, theorized about the potential psychological impact of ECT (Johnstone, 1999). For example, in one study from 1953 the conscious and unconscious attitudes about ECT were studied in 30 psychotic patients. The results were that the majority of patients found electric shock to be a traumatic experience which they would not repeat (Johnstone, 1999). A 1948 study listed 23 potential psychological effects of ECT, which included the destruction of certain defence mechanisms, and the eroticising of the body (Johnstone, 1999). It was proposed in this study that the destruction of these defence mechanisms, described as narcissistic protective patterns, was ultimately positive but was perceived by the individual as having a negative impact.

Other researchers such as Gomez (1975), Hillard & Folger (1977) and Freeman & Kendell (1980) are frequently quoted in regards to the perceived emotional impact of ECT (Abrams, 1997; Johnstone, 1999). For example, Gomez (1975) interviewed 96 patients 24 hours after ECT and asked them about the presence of muscle pain, headache, nausea, sore throat or nasal congestion, memory problems and what they disliked about ECT. Fear of the ECT procedure was found to be the most common complaint with muscle pain and memory complaints being the second and third most common reports respectively. The conclusion made by this study was that the most striking feature was the low incidence of side-effects and that fear of the procedure was minimized (Gomez, 1975). In another classically cited study, Freeman and Kendell (1980), interviewed 166 ECT recipients using a semi-structured interview based on a questionnaire. They concluded that ECT was a helpful treatment, which was not particularly frightening, however, memory impairment was frequently noted (Freeman & Kendell, 1980). The conclusions originally drawn from all of these classic studies were similar in that ECT recipients
found the treatments helpful and were not overly impacted emotionally by the procedure (Abrams, 1997; Johnstone, 1999).

There are several criticisms that can be levelled at the early research done on the psychological and emotional impact of ECT. One critique is that much of this early research is quantitative and had people completing questionnaires, checklists or answering closed questions which are all very restrictive in compiling experiential information (Johnstone, 1999). A second point is that, as Johnstone (1999), points out in her review, there are presumptions made on the part of the researchers and it is quite possible that their results are influenced by other factors. For example, participants may have been unwilling to express themselves openly to the same individuals providing their treatments. A third critique was that initial short-term memory loss, intrinsic to the ECT process, could effect responses. A fourth consideration was that negative findings were sometimes under-emphasized in the conclusions drawn (Johnstone, 1999). The true findings indicated that some participants did report strong negative feelings towards the treatments and the majority felt uninformed about the process (Johnstone, 1999).

Other more recent research on the topic leaves the topic of the emotional/psychological impact open to more speculation. Research conducted in the United Kingdom, (MIND, 1995) outside of hospitals, found that a significant number of people ascribed strong reactions to ECT. These reactions included fear, flashbacks and nightmares (Johnstone, 1999). So the research to date appears contradictory and inconclusive. The gaps and contradictions in information may be in part addressed through changes in research design, sampling methods, data collection, as well as analysis methods. It may also be addressed through an examination of the terms of reference of what constitutes a successful outcome in treatment. Medically speaking, a successful treatment outcome would be a reduction of depressive symptoms. From a feminist
perspective, the recreation of an unequal power structure in the treatment process, combined
with a potentially negative experiential reaction could be perceived as an unsuccessful treatment
outcome. So which outcome is more valid and worthwhile, or should both be considered?

The Wholistic Experience of ECT

Although there is a preponderance of information on ECT as a treatment for depression,
there is very little experiential data on how people feel about the process of ECT and how it
impacts them wholistically (Abrams, 1997; Johnstone, 1999; NIH, 1985). The most current
research to date, and the only one of its kind that could be uncovered on the experience of ECT
appears to be a study conducted by Johnstone (1999). She undertook a qualitative study of 20
people who had self-identified as having found ECT to have a negative emotional impact. She
found through data derived from semi-structured, open-ended interviews that there were
recurring themes of participants feeling coerced, frightened, insane, re-living and equating ECT
with previous sexual abuse, feeling punished, loss of trust in mental health providers and
concern over memory loss (Johnstone, 1999). The implications derived from this research were
the necessity of recognizing the experiences and vulnerability of ECT recipients; the issue of
power and coercion in the consent process; and the concern over the delivery of mental health
services with the potential for undermining rapport and trust (Johnstone, 1999).

The previous literature in this area indicates a number of definite gaps and a need for further
research. One gap is that there is still a lack of substantial information on the wholistic
experience of ECT recipients and particularly in relation to the amount of information available
on the cognitive, physical and psychological effects. A wholistic experiential view can only be
gained through enabling the participants to express themselves in their own terms of reference.
In-depth qualitative interviews which seeks to understand the participant's perspective and to
uncover their lived experience apart from purely scientific inquiry should be utilized (Kvale, 1996). A second issue is that the majority of research available is of a quantitative nature and derived through questionnaires or checklists. This format for gathering experiential data lacks the richness and complexity of revealing and understanding people's lived experiences that qualitative approaches have (Dreher, 1994). Understanding the experience of depression and ECT from the participant's perspective, apart from the medically defined label and treatment outcomes, is most definitely the aim of this research. We must always weigh the benefits of a treatment against its experiential impact in determining its efficacy.

The qualitative data gathered by Johnstone (1999) was definitely information rich, but was limited through only interviewing those who overtly identified as having negative emotional reactions to ECT. It would be interesting to see what themes emerge from people who do not directly identify themselves as negatively impacted. Finally, the wholistic experiences of those most likely to be treated by ECT, older women, have been entirely overlooked in the research, including Johnstone's research.

Purpose of the Study

There are three reasons I have for pursuing this research project. First, as noted at the outset, researchers focusing on the effects of ECT have been remiss in acknowledging or studying the potential experiential impact the process of undergoing ECT can have on individuals (Johnstone, 1999; NIH, 1985). "I expected that repeated exposure would desensitize me to the horror of the treatments. But they become more difficult for me over time. The hands seem rougher, the needles sharper, the band around my skull tighter, the hangover longer" (Manning, 1995, p.130). Interestingly, this comment was from an ECT recipient who found the treatments to be quite beneficial. As we can see, this woman's positive outcome did not
diminish the traumatic experience of the process. At the National Institute of Health's 1985 Consensus Development Conference, it was recommended that research be conducted on individual attitudes towards ECT in order to determine treatment efficacy. Other psychiatrists and researchers have also noted the lack of focus on this aspect of the treatment. "Doctors who give ECT have shown remarkably little interest in their patients' views of the procedure and its effects on them" (Abrams, 1997, p.269).

A second purpose for this study is to understand the experience of depression from the perspectives of these women. As previously noted, depression has become equated with purely physical illness, having primarily biochemical origins, particularly for older adults (Brems, 1990). The necessity of acknowledging the potential circumstantial and structural precedents of depression, and its impact on the lives of women deserves further study (Brems, 1990).

A third rationale is based on the assumption that the inclusion of a person's experience in the healthcare and treatment process is beneficial. From a feminist perspective, the inclusion of experience is often seen as critical for the illumination of theory and practice (hooks, 1989). Within the field of health, the incorporation of the healthcare recipient's experience has been found to be both validating to the individual and informative to policy formation and the healthcare delivery process (Dreher, 1994; Hajdukowski-Ahmed et. al., 1999; Robertson, 1998). This is particularly the case with women, since there is a long history of the exclusion of women's experiences and voices in general within both practice and research (Hajdukowski-Ahmed et al., 1999; Riger, 1992). The inclusion of experience could be instrumental in reinforcing a consumer driven quality of care model and identifying alternative outcome models. This would help to counteract the effects of the current practices which create and perpetuate ageism (Neysmith & Macadam, 1999). As a whole, elderly women are one of the
most oppressed groups in society. As noted, these women still experience some of the highest rates of poverty and lack of power due to structural inequalities and ageism (Grant, 1996; NAPO, 1998). This practice would make the healthcare system more accessible, understandable and more likely to facilitate better health for all people (Hajdukowski-Ahmed et al., 1999; Wright & McKeever, 2000). On a micro practice level, having worked for a number of years as both a facility and community healthcare professional with older women, I can certainly attest to the value of practitioners listening to their clients and including their experiences. The increase in personal self-worth that can be experienced through being acknowledged and listened to is an indicator of health and well-being for the elderly (Grant, 1996; Robertson, 1998). Research has found that through increasing an elder's perceived control over her life and environment, better health and sense of well-being can be facilitated (Clarke, Marshall, Ryff & Rosenthal, 2000; Grant, 1996). It is only through the inclusion of experience in the healthcare evaluation process that this can be accomplished.

Herein lies the important role for Social Work to play in the process. A critical component of Social Work practice with older adults is the mandate of identifying and challenging structural inequalities, assisting in advocacy for groups without power and giving a voice to those who are oppressed (Cox & Parsons, 1994). These roles of Social Work hold particular relevance within the lives of older women since these women are marginalized in society by virtue of the losses they have sustained personally, financially, emotionally and even physically (Cox & Parsons, 1994).

All these factors seem to make the experience of depression and ECT a worthy topic for investigation, particularly in relation to those most likely to be impacted by both - older women.
In response to this recognized gap in the understanding of the role experience plays in depression and ECT, the purpose of this study was to better understand the wholistic, experience of depression and ECT and the impact that experience has on the lives of some older women. Specifically, this research explored how older women have experienced depression and receiving electroconvulsive therapy (ECT) as a treatment.

Some of the questions that this research aimed to explore included:

1. What were these women's subjective feelings, thoughts and circumstances surrounding their depression and how did they make sense of it?

2. What were these women's thoughts/feelings about the necessity and justification for the treatment mode and how were they prepared for it?

3. Is the current practice of informed consent feasible in a treatment structure which eliminates older women's power and which objectifies, pathologizes and patronizes older adult women?

4. How were these women helped or not helped by the treatment?

5. In what ways does their experience of ECT impact how effective they perceived the treatment to be?

6. How can inclusion of experience inform healthcare practices/policy and use of ECT?

7. How has the treatment affected the lives of these older women?

The hope through this research project is to bring a new perspective to the issue and a voice to those most impacted - older adult women.
CHAPTER 2

METHODOLOGY

Within this chapter, I will present an overview of the research methods that were utilized to explore and develop the experiences of older women with depression and ECT. First, I will outline the rationale for the qualitative methodology selected. Second, I will discuss the theoretical perspectives that informed my research process. Third, I will explain the specific steps taken in my methodological and analytic process.

Rationale

This research project employed a qualitative research method. The reasoning behind selecting this method of inquiry was twofold. First, as previously noted, the majority of information on how individuals have experienced receiving ECT has been of a quantitative nature. This quantitative information, based on gathering information through checklists and restricted answer questionnaires, limits the experiential information that can be gleaned to discreet categories (Johnstone, 1999). This type of format for gathering experiential data lacks the richness and complexity of revealing and understanding people's lived experiences that qualitative approaches have (Dreher, 1994). Specifically, within the field of health, the incorporation of the healthcare recipient's voice of experience is important by both validating the individual and informing the healthcare delivery process (Dreher, 1994; Hajdukowski-Ahmed et. al., 1999; Robertson, 1998). A qualitative study is best suited to most accurately capture the complexity of these women's experiences and generate rich data which can be analyzed categorically (Creswell, 1998).
Second, virtually no information to date has been gathered on how older women wholistically experience receiving ECT for depression. Qualitative research is the most appropriate approach for exploring subjective experience (Creswell, 1998).

Theoretical Perspectives

Three main philosophical perspectives informed my method of inquiry and analysis: hermeneutics, feminism and post-modernism.

Hermeneutics

Hermeneutics is a branch of phenomenology involved in the study of the common and viable understanding of the text (Kvale, 1996). A phenomenological perspective attempts to uncover the internal or underlying meaning of lived experiences usually across participants (Creswell, 1998; Van Manen, 1990). The aim of hermeneutical research is not to control or explain, as is with positivistic research, but rather to explore the significance and value of lived experience (Van Manen, 1990). Involved in this process of inquiry is what is termed a hermeneutical circle (Kvale, 1996).

"The understanding of a text takes place through a process in which the meaning of the separate parts is determined by the global meaning of the text, as it is anticipated. The closer determination of the meaning of the separate parts may eventually change the originally anticipated meaning of the totality, which again influences the meaning of the separate parts, and so on" (Kvale, 1996, p. 47).

Kvale (1996), cites Radnitzky (1970), in describing the seven canons of hermeneutic interpretation of text. The first principle involves the continuous back and forth interpretation process between the parts and the whole of the text. The second element is that the analysis ends when the meanings of the themes illuminate a sensible pattern. A third component is the testing of part interpretation against the global meaning of the text for coherency. A fourth canon is that interpretation of the text should remain with the content and try to interpret what it
says about the life world of the participant. The fifth principle concerns the researcher being knowledgeable about the themes generated in order to be sensitive to their expression. A sixth element is for the researcher to remain mindful of their own presuppositions regarding the information and to attempt to account for them within the interpretation. The seventh canon of hermeneutical analysis is that the resulting interpretation must go beyond the text and enrich the understanding of the experience. These are the principles that guided my research process.

Conceptually, hermeneutics informed my research process in two critical ways. First of all the philosophy kept me mindful of the iterative nature of this qualitative research process (Kvale, 1996; Van Manen, 1990). This meant that only through immersing myself in the data and by questioning and re-questioning the information, was I able to gain a deeper understanding of the true nature of the participants' experiences.

The second essential way that hermeneutics informed my research process was to keep me mindful of the impact of my own presuppositions in the process. As noted in the "canons of hermeneutic interpretation" (Kvale, 1996), hermeneutics encourages the acknowledgement of researcher assumptions within the analysis process. Hermeneutics rejects the positivistic notion of human objectivity in research (Van Manen, 1990). Instead it acknowledges that human experiences are part of an interactive process, and so the researcher's interactive experience with the participants becomes part of the research process (Kvale, 1996; Van Manen, 1990). This was a very important component for me because it was impossible for me to distance myself from the topic. Instead, through the analysis process I tried to delineate my own assumptions on the issue and yet still represent the participants' reality. Objectivity then takes on a new meaning in qualitative research and becomes what Van Manen (1990) describes as "remaining true to the object" (Van Manen, 1990, p. 20).
Feminism

A feminist perspective also guided this research project. Feminist theory seeks to inform and empower people to challenge inequalities based on gender, and other areas of oppression (hooks, 1997). The goal of feminist research is to displace dominant oppressive knowledge with alternate views of the world (Riger, 1992). These principles were a vital part of this research project in several ways.

First, this project was grounded in a desire to pursue research methods that would explore and honour the experiences of the women who participated. A qualitative method of inquiry upholds the tenets of feminist theory. There is much to be learned through placing more value on the personal truth and experiences of women. An aim of feminist scholarship is on elucidating the truths of women's existence through their own perceptions, but this cannot be accomplished through using methods, constructs and theories which have been developed without consideration to a woman's perspective (Foss & Foss, 1994). As noted, the voices of the women most impacted have been all but ignored in the research on this topic. Feminist theory supports the valuing of experience, life narratives and personal truth in research (Foss & Foss, 1994; Riger, 1992). More specifically, feminist thought holds that it is only through the studying of women's experiences through their own perspective that a clear and accurate picture of what impacts their lives and creates their reality emerges (Foss & Foss, 1994; Harding, 1997).

Second, as pointed out in the conceptual context, the issue is a gendered one and the prevailing knowledge on this topic frequently overlooks this fact and its implications. Feminist theory challenges the existing beliefs and practices in order to reveal the underlying assumptions and balance of power (Riger, 1992). "A feminist method should produce a study not just of
women, but also for women, helping to change the world as well as to describe it (Riger, 1992, p.736). If an issue is gendered it is important to look at not just superficially why this is happening but all possible structural components lending to the issue. It becomes essential then to study the phenomenon from the perspective of those most impacted, older women.

Third, feminist research seeks to equalize the power differential between the researcher and participants (Riger, 1992). It was my belief that the issue of power was important in the understanding of this issue. It then became critical to equalize the power differential within the research process as much as possible, in order to avoid recreating the same circumstances that I felt I might be studying. This aim of equalizing power was undertaken in several ways. First, for example, participants were encouraged to take control of the context of the interview, and speak of the elements of their experience that they felt were important. Open ended questions were posed and although I wished certain topic areas to be covered during the interview, I did not enforce a specific agenda of questions. Second, another attempt at equalizing power was that the interviews were arranged at the convenience of the participant and at the locale of their choosing. The location of the interviews ended up being in the participants own homes in all cases. Third, I tried to respond to participants' questions about myself and the research project in as openly and forthright manner as possible, rather than maintaining a traditional "objective" and distanced approach. Fourth, transcripts and data analysis was offered back to the participants in all cases in order to seek feedback and as a check for accuracy. Fifth, I was sensitive to the nature of the interview topic and process and did not push participants to elaborate on anything that they were not comfortable discussing, even at the expense of at times not accumulating as much information on a specific area as I might have liked.
Post-Modernism

The third philosophical position which informed my research process and one I believe compliments the feminist position and hermeneutics, is post-modernism. Post-modernist perspective rejects the positivistic construct of an objective truth or reality. Instead, reality is seen as being socially constructed and culturally bound (Pardeck, 1994). "...culture should be viewed as invented or created. Human values, beliefs, and commitments, taken together to form praxis, are the core of social existence (Pardeck, 1994, p.1). Language is also socially constructed and is a powerful player in mediating what "truth" and "reality" are thought to be (Pardeck, 1994). Hand-in-hand feminist theory and post-modernism deconstruct the notion of reason, knowledge and concepts of self to reveal the effects of supposedly neutral constructs such as gender (Flax, 1997). Gender, for example, is a highly value laden and socially created construct, which interacts with power and privilege to leave women disempowered.

Hermeneutics and post-modernism compliment each other from the position that proponents of both perspectives believe in the interactive and subjective nature of reality. Post-modernism asserts that the acquisition of knowledge whether through research or other means is not just a means-to-an-end process. It is an interactive, ever evolving process of subjective discovery which is much the same as the hermeneutical position (Van Manen, 1990).

Post-modernism has relevance to my current project in several ways. First, post-modernism would assert that since there is no one reality, there is also no one way to view illness and specifically depression. The concepts of health, wellness and illness are social phenomena whose definition has changed remarkably through time (Longino, 1997; Pardeck, 1994). "Objective", empirical measures such as demographics, mortality rates and physiological
indicators have been used to quantify and validate concepts of health and illness as objective truths (Pardeck, 1994). In this same way the issue of depression in women has been treated both clinically and theoretically in a very empirical fashion, and generally only by one paradigm. The biomedical model, as earlier discussed, asserts that differences in rates of depression between men and women are primarily the result of biological differences (Brems, 1990). By this position the very basis of depression as being a human emotion which is experienced has been removed from the equation. Just as post-modernism would challenge the notion of one view of depression and treatment so does this research.

Second, a fundamental element of post-modernism is the possibility of alternative realities and views of self. Post-modernism asserts that people's identities are "invented" individually based on interactions with the world around them and particularly with those perceived to be in power (Pardeck, 1994). There is no typical person and one's self-concept becomes something that must be interpreted (Pardeck, 1994). The aim of this research was in gathering experiential data in an attempt at unveiling the alternate realities these women held. We construct our world through the language we use (Kvale, 1996). Our knowledge and reality is constructed through conversational interactions with others. The words chosen and often subtle undertone of speech used for example, are indicative of our realities (Kvale, 1996; Van Manen, 1990). Furthermore, our realities and sense of self are often dynamic and even contradictory (Van Manen, 1990). Through the conversational interaction I engaged in with these women, I was able to gain a sense of these women's experiences through their descriptive process and access a new understanding of their realities. A reality that was quite different than found in other literature on the topic.
Third, post-modernism asserts that although there may not be an objective truth, there is still the existence of knowledge (Flax, 1997). Knowledge however, is defined and regulated by those with the power to do so (Flax, 1997). Knowledge dictated by those with power is a theme which has particular relevance to this project. These participants had very dynamic and impactful relationship with the medical system through which they were treated.

The Research Process

The three perspectives of hermeneutics, feminism and post-modernism informed the decision making on research process, design and analysis. The components of the research design will be discussed throughout this section.

Locating Participants

The focus of this study was on the experiences of women over the age of 65 with depression and treatment with ECT. The design utilized was a purposive sample. Purposive sampling means that participants were chosen on the basis of whether they could lend insight to the topic (Maxwell, 1996). In other words, participants were not randomly selected since I needed to ensure that they had received ECT for depression and were able to lend their view on the issue.

The study was phenomenological and so a sample size of between six and eight participants was necessary in order to gain a good depth and breadth of information (Creswell, 1998). The specific criteria necessary for inclusion in the study were:

- Being female
- Over the age of sixty five
- Having had depression at some point as an older adult
- Having had ECT for depression as an older adult that was voluntary
- English speaking
• Able to legally consent to treatment and the interview process

• Able to relay their experiences verbally.

Once permission for the research was gained through the University of British Columbia Behavioural Research Ethics Board (see Appendix A), I began to look for potential participants. In order to locate participants, I spoke in person and by phone to a number of independent community organizations, several Regional hospital and community geriatric mental health programs (see Appendix B), and posted advertisements for my research at a number of community programs and gathering spots for older adults within the Lower Mainland. I explained the purpose of my research, and the commitment it entailed to the service providers. I requested that the service providers contact, on my behalf, any woman over the age of 65 who they identified as potentially suitable for the study, in order to bring my study to the attention of women who might be interested in participating. If the person contacted expressed interest in learning more about the study, permission was requested by the service provider to allow them to supply me with the woman's phone number so that I could contact them directly to provide further information.

Over a five month period between February, 2001 and June, 2001, fifteen women were identified as potential participants through either contacts with community organizations who provided services for older adults, geriatric mental health teams or hospital programs. No responses were received from recruitment advertisements posted. However, even with a relatively large number of potential participants identified, I experienced great difficulty in obtaining an appropriate number of participants for the study.

Due to the sensitive and controversial nature of this study it was not surprising to me that some individuals were unwilling to participate, however, the degree of difficulties I experienced
were somewhat surprising. The two most common reasons for not wishing to participate were a
general unwillingness to discuss the topic and/or reluctance to discuss it with someone unknown
to them. Two women expressed specifically that since they were done with the experience they
did not want to revisit it. Three other women declined involvement due to current health
concerns. In the other cases, the women indicated to the service provider who contacted them
that they just did not give their permission for me to contact them. In the case of two
individuals after initially agreeing to participate, the women changed their minds based on their
physician's recommendation that they not participate. At the time of my recruitment process,
Riverview Hospital was undergoing an investigation of the increased frequency of ECT use on
older adults in its geriatric psychiatry program. This could account for some participants'
unwillingness to participate as well as the physicians' suspiciousness regarding the intent of my
research.

Ultimately, six women participated in the project. Sandelowski (1995), cites Morse (1994)
in stating that for a phenomenological study investigating the essence of an experience it is
necessary to have about six participants. Larger participant samples lend a greater breadth of
experience, however, the depth of information and analysis is compromised since the increased
amount of information becomes overwhelming to scrutinize and detail is lost. Since a
purposeful sampling method is utilized, participants are selected based on what insight they can
add to the knowledge on the phenomenon being studied (Strauss & Corbin, 1998).

Participant Profiles

All six of the women who participated were located through contacts made with various
Regional hospital and community geriatric mental health programs within the Lower Mainland.
The age range of the participants was from 71 to 89 and all were Caucasian.
A brief overview of each participant is provided below.

Hilda is an 81 year old woman who immigrated to Canada from England in the 1950's. This was her second relocation since in her early 20's, she had left her home in an Eastern European country at the time of the Russian Revolution. She immigrated to Canada with her husband and two children. She divorced her abusive husband over 20 years ago but supported him through a prolonged illness for 12 years until his death. She began a very loving relationship with another man which lasted over 16 years but they never married. He died over 2 years ago. She currently lives independently in the community in a self-owned apartment. Hilda cites a history of depression with suicide attempts, which started in her early 40's after she immigrated to Canada. She has been treated through various acute and out-patient programs throughout the Lower Mainland. She has received ECT at several hospitals and states she has had at least 40-50 ECT treatments. It has been over 5 years since her last ECT treatment. Hilda is currently on anti-depressant medication and has been on several different medications throughout the years.

Judith is a 71 year old, Canadian born woman. She has been married more than once and has one child. Judith is currently single and lives independently in the community in a self-owned apartment. She describes her life as contented and she likes to be quite precise and organized in what she does. Judith was an administrative assistant for the same company for over 17 years. Over 7 years ago, just prior to her retirement Judith was laid-off. Subsequently, she experienced her first depression and never returned to

---

1 Names given are pseudonyms and some personal information has been altered.
work. Judith has been treated at both in and out-patient programs locally and received
ECT as both an in-patient and as an out-patient. Judith has received over 70 ECT
treatments as an out-patient and she is not sure how many she received prior to this as
an in-patient. She is currently receiving maintenance ECT as an out-patient once a
month and is on anti-depressant medication.

Margaret is a 78 years old, Canadian born woman. She has no children and stated that
she regrets that she never was able to marry. She is currently living independently in the
community in co-op housing but is working on being waitlisted for an intermediate care
facility. She welcomes the move to a care home for the extra support and company of
peers. Margaret identifies a long history of depression with suicide attempts starting
when she was in her 30's. She acknowledges that the depression began after her father
committed suicide and she moved to the coast from the prairies. Throughout her life she
struggled with maintaining employment and higher education through her bouts of
depression. She first became a teacher and then returned to school to become a nurse.
After obtaining her BA she attempted to return to university to go to library school but
was interrupted by another severe bout of depression and never completed that degree.
She has been hospitalized for depression and treated with ECT a number of times with
the most recent being just over a year ago. She has always received the ECT treatments
while being in hospital but she does not remember how many treatments she has had
over the years. Margaret is also currently on anti-depressant medication.
Velma is an 89 year old, Canadian born woman. She was married for many years and was widowed about 7 years ago. She had 3 children, one of whom died in the past 2 years. She is currently living in a senior's independent living complex. Velma is very definite about her views and has a strong sense of privacy and respectfulness. Velma does not identify herself as being depressed although as she told me, she believes her daughter could tell me more about what had been going on. She identifies one daughter as being extremely supportive and involved. Velma remembers her first ECT treatments as being prior to her husband’s death. She has been treated primarily as an out-patient at various hospitals locally. She could not tell me how many ECT treatments she has had over the years, but she was very clear as to which programs she disliked. Her last treatment had been 2 months prior to our interview and she said she had been told it would be her last. Velma is currently taking anti-depressant medication.

Doris is an 80 year old, widowed woman who immigrated to Canada from England. She came to Canada with her husband and two children when she was in her 30s. She describes her two children as being very supportive and involved, despite one not living locally. She is currently living independently in the community in a self-owned apartment. Doris identified her depression as starting around the age of 70. At age 70, due to illness, Doris retired from working in the book department of a large department store where she had worked for over 20 years. Doris had returned to work after her husband’s death at the age of 48. She described her work as being very enjoyable and rewarding. She does not recall any feelings of depression prior to that time. Doris has also been treated at both acute in and out-patient programs but has primarily received
ECT as an in-patient. She too does not recall how many ECT treatments she has received. Doris had been having ECT treatments up until about 1 month prior to our interview. Doris is also currently on anti-depressant medication.

Peggy is an 85 year old, Canadian born woman. She has no children and stated that she had chosen not to marry. She is currently living in a seniors assisted living complex. She was the fifth youngest of a family of 14 and was one of three surviving siblings. In her 30's, after her father died, Peggy moved here from another province to be closer to one of her sister. Peggy worked for many years and described to me several clerical positions she had held throughout her life. She enjoyed working and described it as a very good time of her life. She too did not identify herself as experiencing depression and described her life as being quite happy; however, she felt that there might be something wrong which she accepted treatment for on the advice of her doctor. Peggy has been treated primarily through out-patient programs although she has been hospitalized in the past. Peggy was currently receiving ECT once a month as an out-patient. She was unable to tell me how many treatments she had had but she did not believe that she had not had very many. Peggy was also currently on anti-depressant medication.

Interview Process

All participants were given a choice as to the time and place they would like the interview to occur. All of the participants chose to be interviewed in their own homes. My role in the process was as an interviewer, but also as a source of encouragement. "If qualitative research is a voyage of discovery, then the researcher is the captain and the navigator of the ship. It is
difficult to underestimate the significance of this role" (Padgett, 1998, p.18). I wanted to gain insight into these women's experiences and to encourage them to discuss the issue to the extent that they felt comfortable. It was in my best interests then to promote an open and safe environment for these women to tell their stories. It was my hope that by conducting the interviews in the participants' own homes and at their convenience that this was an initial step towards making them feel comfortable.

There were several identifiable advantages to this interview setting. First, it helped minimize stress for the participant by being in a familiar environment. Second, it reduced some of the inherent power difference between the researcher and participant by allotting the participant more control and comfort in an environment of their choosing. Riger (1992) states that feminist research is aimed at challenging inequities in power and revealing the impact this has on how reality is constructed. The focus of my research was to challenge accepted practices through trying to create a safe environment for these women to describe their experiences. Third, it was also important for there to be as little perceived connection between the environment, myself, the participant and the medical system through which they were being treated. This was in order for the participant to feel as comfortable and free to express themselves as possible. Johnson (1999) stated, in her review of research on the psychological impact of ECT, that a critique she levelled at previous research done was that the results were possibly influenced by the connection between the interviewer, interview environment and where the participants had received treatment. Participants may not have felt comfortable openly commenting on the process within the environment and to the people who were connected to their treatment. I wished to avoid this association as much as possible with these participants. Fourth, in undertaking research with elders further practical considerations are necessary as to the location
of the interview. Accommodations should be made for the potential of decreased mobility and limited financial resources available that limit transportation accessibility (Cox & Parsons, 1994). All these factors made the use of a participant's home a very viable option for the interview.

Disadvantages to this choice of locale turned out to be few in the case of my research. The most disruptive element was that in all but one of the interviews the telephone rang and interrupted the interview. This temporarily disrupted the flow of the interview, but in all of the interviews, participants were able to reconnect and continue with what they were saying. The other disruptive feature associated with interviewing in the participant's home can be distractions from other people in the home. All the participants lived alone so this was not a problem, except with one interview. In this case, a family member was present when I arrived for the follow-up interview and initially wanted to be involved in the process. However, after explaining the nature and intent of my research, the family member voluntarily left so that the participant and I could begin.

As previously mentioned, the research was done as a qualitative phenomenological study so my focus was in to gain in-depth and information rich data on the depression and ECT experiences of these older women (Creswell, 1998). Prior to the interview process beginning, an informed consent document was signed (see Appendix E). The interview itself was semi-structured. According to Kvale (1996), a semi-structured interview creates a balance between allowing the researcher to pursue the necessary themes, while enabling participants the freedom to go in-depth in areas they wish. It also entails allowing the participant to speak freely about their experience within the guidelines of covering certain topics of interest to the researcher.
I began each interview with an open-ended question that asked the participant to describe circumstances of their life prior to the onset of their depression, such as what they remembered of their childhood, relationships, work, and outstanding events in their lives and the feelings that were associated. This was designed as a means for encouraging the women to open up and to create a backdrop of understanding as the rest of their experiences unfolded; however, most of the women were not extremely forthcoming about their experiences. Further questions were designed as prompts to enable the women to begin speaking on the topic. There were a number of areas of experience that I wished each participant to speak on. To accommodate this I had developed a series of six open-ended partially sequential questions that could be asked of the participant if information was not forthcoming or certain topics of interest were not being covered (see Appendix F). After the initial interview, information and themes generated from the preceding interviews were also addressed in order to build on or alter emerging themes. To accomplish this I would say to the participant that others had expressed a certain belief or understanding in their interview and then ask the participant what they thought about the topic. This type of questioning seemed to generate some of the most valuable feedback on specific themes. Each interview lasted from between sixty minutes and up to almost two hours.

Permission to audio-tape the interview was requested and granted by all participants. Some of the participants were more reluctant and conscious of the taping process than were others. At no time did any participant request the tape recorder be turned off nor did I deem it necessary to do so other than to change the tape or turn it off due to an interruption. Once into the interview, participants generally did not make mention of the tape recorder again, however, only three participants would agree to be audio-taped a second time. I believe that for three of the participants, although they seemingly voluntarily agreed to participate in this project, when they
truly felt they had a choice as to what extent they participated, they expressed their true
discomfort in the process. I interpreted this as possibly being a part of the power and choice
dynamic which will be addressed at length in the Findings and Discussion section of this paper.

I took minimal notes during the interview since I wished to give the participants my
undivided attention. I also found that if I made notes while the women were speaking it was
distracting to them and they would stop speaking or change the topic. Following the interview,
I recorded my initial reactions, thoughts and impressions of the interview process on computer.
This included highlighting any prominent comments made, themes identified, specific issues
raised and my own reactions to the interview. I also kept a hand written journal of my thoughts
regarding my research method and analysis process. This journaling process is a part of the
qualitative research journey and brings clarity to the process (Maxwell, 1996). The exception to
not taking notes during the interview was with the two women who agreed to the follow-up
interview, but would not agree to be audio-taped again. In both of these cases I did make some
notes during our second interview.

Follow-up interviews occurred after the tapes had been transcribed and the participant had
the opportunity to review the transcript. I transcribed all the tapes verbatim and included
pauses, stammers, grammatical errors, repetition as well as changes in tone, inflection and
speech rate. I transcribed all the interviews and removed personally identifying information
from the transcripts. Upon return of the transcript to the participants, five of the participants
agreed to a follow-up interview, the sixth participant did not wish to be a part of this process.
The follow-up interview ranged from twenty minutes to one hour. 
Data Analysis

A combination of individual case analysis, discourse analysis and thematic categorizing methods were utilized in order to accomplish the data analysis. First, the use of individual case analysis involves making sense of an individual narrative as the story unfolds (Kvale, 1996). Each person's interview was read and re-read in context and as recurrent ideas were identified and substantiated by further information, a new story-line emerged and was literally re-written. Second, discourse analysis as a technique is the product of post-modernism and seeks to discover the specific and socially dominant ideologies which guide an individual's belief system (Kvale, 1996). There is the belief that the words we use are a powerful expression of who we are and what principles guide our lives (Van Manen, 1990). McGowan, Morouney & Bradshaw (2000), cite Van Dijk (1997) in describing discourse as how people use language in social contexts as a communication of their beliefs and value systems. So what words the participants used, how they were spoken all in relation to the context the language was used in, became very significant in the analysis process and was dually noted. Third, a categorizing strategy based on a hermeneutic phenomenological approach was the overall method utilized for the data analysis. As previously mentioned, a phenomenological hermeneutics approach aims at understanding experiences through interpreting the meaning of separate parts of the text within and between individuals (Kvale, 1996). A categorization strategy based on this approach involves reading the data and picking out key ideas and themes. These themes are further tested and adjusted according to new information as it arises through the data. The end result is an understanding of the meaning of the separate parts which may be different than the totality of each individual experience (Kvale, 1996).
The strengths of a categorizing strategy lie in its ability to seek a deeper and more meaningful understanding of the collective experiences of the participants and of the deeper issues which lie behind the experiences (Kvale, 1996). Another strength is that it helps preserve confidentiality of participants since themes become the issue rather than individuals. The use of this strategy also avoids the struggle of becoming the voice for the participant and potentially misrepresenting them.

The data analysis process started immediately after my first interview, when I developed my field notes. These notes recorded my impressions, immediately identifiable themes, important points and any other comments I had in regards to the interview. This process, although limited and selective in what is remembered, does serve as an immediate organizing technique to information that was prominent within the interview (Kvale, 1996).

The analysis process continued as I transcribed verbatim each of the audio-taped interviews after completing each interview. As I transcribed, I made notes on statements and phrases that seemed to hold significance in revealing the experience of older women with depression and ECT (Coffey & Atkinson, 1996). If emphasis in speech was placed on a particular topic such as the participant speaking louder, reiterating a point, or using a particular speech pattern, it was noted as I transcribed the data. I attended to both content but also to how the story unfolded. This began the process of individual case analysis for I was trying to make sense of each woman's story in it's own context. These points were also highlighted and noted for the possibility of an emerging theme and were identified and coded more significantly (Coffey & Atkinson, 1996). For example, it was became very evident during the transcribing of each tape that several of the women spoke in second person while describing their experiences with depression and ECT. This was dually noted and coded as "disconnectedness". These notes and
highlighted themes were used to guide my next interview in order to explore certain issues that I may not have thought of in my original interview format.

Ideally, I would have analyzed and highlighted the prominent themes in each transcript before proceeding onto the next interview (Kvale, 1996). This was not possible in all cases due to the timing of obtaining referrals for participants. All interviews, however, were transcribed prior to the next interview and, as described, at least a cursory analysis was made of the transcription. This helped to identify topics and themes that could be asked of succeeding participants. This practice provided an extra measure of ensuring that the results were discussed with all participants and so were an accurate reflection of their experiences (Creswell, 1998). It is also a practice that is consistent with hermeneutic research. Specifically, that there is a constant back and forth dialogue with the data so that new data is always informed by and helps inform the data. (Kvale, 1996; Van Manen, 1990).

Following this preliminary case specific analysis, participants were provided with a copy of the interview transcript and a second interview was arranged, in order to gain feedback. During this second interview the participants had an opportunity to clarify, expand on or change information recorded during the first interview. I also had an opportunity to ask their views on certain dominant themes that seemed to be arising out of the data. Three of the participants agreed to having this interview audio-taped as well. This additional information provided me with further data, verification and alterations to the emerging ideas.

Although all participants were offered the opportunity to review the transcript and give me feedback on the information, not all the women wished to participate in this process. Three of the participants readily agreed to review the transcript, discuss prominent points and be recorded again. Two of the women were willing to review the transcript and verbally discuss the
information but were not willing to be audio-taped again. In these cases, I made more notes during and after the follow-up process in order to record their feedback. One woman did not wish to be involved in any follow-up process. As previously noted, I see this unwillingness to further participate in the process as indications of the power and choice dynamic at play which will be discussed at length in the succeeding sections. Luckily, in the one case since she was the last participant, I had previously analyzed the other interview data and was able to be quite specific with her during our one interview in checking out themes which had arisen from the other women. Generally, the women agreed with the preliminary information and added, deleted or adjusted some points as it related to their specific experiences.

After I had received input from the participants, I engaged in a more in-depth analytic process which is described as follows:

- I first re-read each transcript to gain a sense of the information as a whole (Sandelowski, 1995). Then through an individual case analysis technique I read the transcript several times in detail, seeking to understand the individual narratives of these women (Sandelowski, 1995), and trying to identify the discourse that guided their beliefs (Kvale, 1996). I would make summary notes and try to recreate the story as I was interpreting it. Identified discourse would form the basis of the themes that would be further analyzed through the categorization strategy.

- I then went back through the transcripts in detail and coded the information line by line and section by section with different coloured highlighters and by using code memos in the margin to make note of reoccurring and significant words, phrases, comments and concepts also looking for emerging themes. This was the beginning of the thematic categorizing (Strauss & Corbin, 1998). The process can be seen as an exercise in questioning and testing
the data. As a concept arose through the data it was recorded in the margins as an idea. Further information was tested against these concepts to support, disprove or expand the dimensions of the concept, thereby creating a theme. The undertaking described is a circular process rather than a linear one. During the analysis I moved back and forth between reading and memoing and the process of describing and interpreting the data (Coffey & Atkinson, 1996).

- The next step was to look at themes and discourse that arose across the participants and test out each piece of information as to how similar or different it was from that expressed by other participants. Meaning interpretation was also utilized to gain a deeper and more meaningful interpretation of the data which is consistent with hermeneutics (Kvale, 1996). Application of the feminist and post-modernist theoretical positions enabled me to test and interpret the data in light of these philosophies. It allowed me to see past an essentialist view of the data and pose alternate possibilities to their meanings.

- The analysis was then taken back to the participants in order to verify and further re-fine the analysis (Creswell, 1998). Only three of the participants agreed to being involved in this stage of the research, however, their feedback was invaluable and quite consistent in confirming a number of the themes.

- This analysis technique was a lengthy and time consuming process but one which revealed a new and very interesting picture of the experiential data. Combined across the transcripts, what came forth was a collective understanding of the experiences expressed by these women which was quite different than the initial interview information. The data analysis process ultimately became an exercise in investigating the underlying essence of the experiences (Kvale, 1996).
Credibility

Steps to ensure the credibility of the data were worked in throughout the research process. As outlined by Creswell (1998), descriptive, interpretive and theoretical threats to the credibility of the research were of concern and were dealt with through three verification procedures. The procedures were member checks, external auditing and negative case analysis. Overall credibility of the study was facilitated through prolonged engagement. Only one individual was interviewed only once, two were visited twice and three women were seen three times. This engagement with the participants helped to establish rapport and to generate more information rich data (Creswell, 1998).

Both descriptive and interpretive threats to credibility were also addressed. Descriptive validity refers to whether the transcripts accurately reflect the views of the participant; whereas, interpretive validity refers to the accuracy of the analysis (Maxwell, 1996). Both types of validity were accounted for by way of member checks. This entailed participants having the opportunity to check raw and analyzed data for its accuracy (Creswell, 1998). All participants were given the opportunity to review the transcribed interview and make additions, omissions or changes to the transcript. All but one of the participants took the opportunity to review the transcripts and make changes or additions as they saw fit. All the women were also presented with the opportunity to meet with me a third time in order to review and discuss the analysis. Three of the participants engaged in the analysis review process.

Interpretive validity was also addressed through an external audit process that involved an advisor on several occasions reviewing the data in order to see if the same conclusion could be drawn through the data analysis (Maxwell, 1996).
Theoretical validity refers to the necessity of accounting for contradictory information or negative cases in the final analysis (Maxwell, 1996). A negative case analysis process was incorporated into the research project to accomplish this check for credibility. This is when the data was analyzed and reanalyzed in order to incorporate extreme or even oppositional information (Creswell, 1998). Through this process of analysis, as contradictory information was found, other interpretations of the data were sought in order to incorporate extreme or negative cases. Through this process even seemingly contradictory information was accounted for in the final analysis. The aim was that through a combination of these strategies the quality and credibility of the information and analysis could be maintained.

Summary

A qualitative research design provided a framework for illuminating the experiences of older women with depression and treatment with ECT. Hermeneutic principles established an iterative process which helped to develop a deeper understanding of these women’s experiences. Feminist theory helped to identify and understand the potential for power imbalances and gender bias involved in the issue. Finally, post-modernist ideas shed light upon the social construction of reality, knowledge and its impact on experience particularly in the field of healthcare.

It is certainly not my intent with a sample of six participants to attempt to generate theories or generalize these women’s experiences to that of all older women who have been depressed and received ECT. Instead, as is the value of qualitative research, my aim is to develop an in-depth understanding of how these women make sense of their experiences in order to create an awareness of the issue, raise new questions and present an alternative understanding to that
which currently exists in literature. The strength of qualitative research is on increasing awareness of a specific phenomenon and developing insight into an issue (Sandelowski, 1995).
CHAPTER 3
FINDINGS

The data analysis unveiled a similar pattern of experience across all of the participants. It is an experience that reveals itself to be a metaphoric journey. The journey however, is a unique and complex one that is akin to an alien invasion and rescue experience. This journey plays out in four distinct parts: the invasion/becoming depressed; finding allies/conditions of getting help; the rescue/the treatment; and the journey home/hope for recovery. Woven throughout each of these four sections is the dominant theme of power and its various dimensions. Through describing the story of these women's experiences with depression and ECT in this way, a very unique and engaging picture of their experiences emerge.

The Invasion

What was common to all the women was how they seemed to describe their encounter with depression as an older adult. The image that was created as each of these women spoke of their battles with depression could be likened to an alien invasion experience.

Unexpected Event

First of all, with all six of the women I interviewed, depression was described as coming upon them quite suddenly and seemingly without warning.

…it's just that the depression seems to all of a sudden hit you

Words such as "hit" seem to highlight the disturbing nature of this surprise attack and how these women truly felt overcome and violated by the depression. Other comments on the unanticipated nature of the depression seem to indicate a state of almost apologetic befuddlement or discouragement that they did not see it coming.

I didn't realize, I didn't see something coming. I didn't realize.
Three of the women clearly expressed a sense of discouragement and frustration that they could not seem to predict when they were becoming depressed. Their desire was to be able to tell when this was happening so that they could either do something to prevent it, or at least know to get help in advance.

*Well I hope that this, if there's going to be another [depression] coming on that maybe I will this time. But I would say that..I haven't know up until the last time that I was hospitalized*

Only one of the women I interviewed said that she now is able to recognize when she is becoming depressed so that she can seek help.

*When I have a certain dream I know that I, my depression will start..Ya, that's if I'm somewhere where there's a lot of deep, dark cold water. Specially, if I go into the water..As soon as I dream that dream I know my, my, I get depressed. But I haven't had it, thank goodness, for quite a while (chuckle)*

This participant tried to make light of this particular dream sign as she spoke about it; however, it was clearly a very disturbing and frightening omen for her and one that she actually did not take lightly herself. The description of the deep, dark cold water seems very symbolic of her experience of falling into depression. Her slight stumbling on her words and change in tone as she spoke of this dream and its significance belied her light-heartedness.

The unexpected nature of the depression seems also highlighted by the fact that five out of the six women interviewed did not identify any specific circumstances in their lives that would lead to their depression. The idea being that if the women recognized some emotional or stressful event in their life, then they might be able to predict or at least identify their depression more readily.

*I..don't.. see..a relationship between my several depressions and an obvious cause. So it isn't as if there was some.. trauma that would pretty well indicate that, that brought on the depression. I don't have an explanation like that.*
Through the use of the word "trauma" it seems that this participant believes there has to be an extremely momentous or life altering event in order for there to be a connection to depression. She does not rule out that life events can create depression, but she does not believe it to be the circumstance for her. This belief was a very common one amongst the participants and in some form or another was expressed by all of the women. This is despite all of them describing to me some very difficult and even traumatic events.

Oh ya, I had a good friend that died but I don't think that was the cause of it [depression]. That was a year before...ya, we missed him...we used to see him a lot, he was a good friend [lost in thought]. But then he was a good friend to a lot of people. [Comment said rather matter-of-factly]

In both of the above comments, the participants seem to feel that there needs to be an immediate cause and effect relationship between the events occurring and the depression. In the second comment, a year appears to be too long of time to consider an emotional event to be a potential catalyst for depression. This participant seems to further minimize the impact of this death by speaking in the plural "we" and thereby taking the focus off herself and dispersing the significance of this event.

Just as with the above comment, there was the overwhelming tendency by all of the women to downplay some quite difficult life circumstances.

Well..it was a normal..happy life... my marriage wasn't very happy. My husband..uh..used to drink too much and beat me up... (chuckle)

This comment highlights a rather blatant contradiction and distinction the participant has made between her actual life events and her perceptions of life. She acknowledges that her life was not as good as it seemed to be, yet, she does not necessarily see this circumstance as having any true impact on her life or emotional health. Like the above statements, many of the comments made about difficult life events were made rather nonchalantly, matter-of-factly, or in a
humorous manner. This practice also seems to indicate the diminished significance these women placed on their life events. Some other examples of life circumstances that were discussed include: death of parents at an early age and/or by suicide, death of spouses, death of children, death of siblings, previous abortions, loss of employment, abuse, loss of homes, moving against one's wishes, divorces, and physical illness. In the discussions of all these circumstances, very little emotional significance was placed on the event. Instead, most participants made rather dismissive comments about their experiences. One woman in response to a question about how she felt about both her mother and father dying quite tragically, responded:

*Oh ya, well..we're sorry but you took it [resigned]..I took it normally.*

Her comment seems to indicate that death, even unexpected and tragic death is just a part of life and one was expected to just accept that.

There was only one participant who made a link between events in her life and her depression.

*I think I'm the product of two dysfunctional families (laughter) .. I was emotionally, I'd say I was numb and then I felt I..began to grieve for my father and other things that had happened and I..became..depressed [said in a lowered voice].*

In the case of this participant, there is a link made between the impact of the death of her father, the circumstances of her childhood and other life events and the depression she has experienced throughout her life. Although this connection is made, she too downplayed the significance of the statement by making light of it. Further along in our conversation, she even discredits her belief by reiterating the biochemical nature of depression. Throughout my conversations with several of the participants, further information pertaining to the tendency of all the women to minimize their experiences was revealed.
I don't know, I guess I'm not uh, very...aggressive...I don't know how to blame people for things you know. [Hilda]

Because as I say, you just, you just didn't discuss anything bad. [Margaret]

It seemed that the gendered societal messages of putting up with circumstances, not talking about difficulties, being cooperative and focusing on others rather than yourself seemed to be well-learned by these women.

Outside Entity

Second, in addition to all the women perceiving the occurrence of their depression as quite unanticipated, they also all spoke of the depression as if it were an external force invading them.

..everytime my depression came on years ago, I phoned my doctor..

The use of the words "came on" gives a sense that she is experiencing something that came from outside of herself and overtook her.

But like I say it [depression] comes out of the blue sky, it doesn't warn you, give you any warning.

In the above passage, depression is spoken of not only as coming on unexpectedly "out of the blue sky" as this participant describes it, but also as if it is a separate entity and comes from outside of the person. The use of the word "it" to name the depression seems to reinforce this notion of the depression as being something tangible and separate from themselves. The use of objectifying words such as "it", "that" and "something" to name the depression was common to all of the participants and seems to imply that the depression is unknown and has a life of its own.

Another characteristic of distancing the experience of depression from themselves is identifiable through the use of the second person "you" to describe their experiences.

You feel it [depression] in your whole body all of a sudden..
From this passage we see how the participant feels quite literally taken over or invaded. Four of the participants made use of the second person when describing their experiences with depression. The use of "you", "you're" or "your" gives a sense of separateness from the experience of depression. What is inferred from this is that somehow the feelings are seen outside of themselves and they experience their depression as the "other" looking in on what is happening but not really seeing it as a part of themselves. What seemed more significant about the use of "you" to describe their experiences was that the switch from using "I" to "you" was only made when these women were talking about the depression, their ECT experiences and some difficult life experiences. This switch to using second person in speech was something that the women were not conscious of doing. In a discussion about this element, the three women who provided follow-up on the analysis agreed that they distanced themselves from the experience and saw the experience as something outside of themselves.

Interestingly, two of the women I spoke to did not overtly identify themselves as being depressed, yet they did acknowledge that there was something different going on with them that others labelled as depression.

*I don't ever even remember feeling down. And I don't know where it [depression] came from.*

For these two women, there was a heightened sense that whatever was happening to them came from outside of them. As the above passage notes the women have no idea where the depression "it" came from. They do not recognize depression as coming from within so it must be outside of themselves. Despite these two women not explicitly labelling themselves as depressed, they were still able to describe their experiences, as will be shown, using their own terms of reference.
All-Consuming Nature

Third, all of the women described their experiences in a way that supported the belief that depression was an extremely powerful outside force, which they felt they had no control over. For four of the women, depression was a tangible and fearful element which invaded their very being, literally taking them over.

*Well it [depression] feels like your stomach goes into a knot and uh you know everything seems so awful that you can't cope with anything. You're scared to death almost ... Ya you're very scared to live at all, you wish you could escape it...It's, it's a terrible feeling.* [emphasis original]

The above comment conveys that depression was undeniably a frightening experience for this participant. All of the women seemed to feel a lack of power or control over the depression, predicting its occurrence, and the course it would take.

... Well I guess I would say in those cases that I didn't, there's nothing I knew to turn it [depression] back.

This comment not only highlights the unanticipated nature of the depression but also a sense of being out of control of the experience. There was nothing she felt that she could do personally to combat the depression or prepare for it.

Three of the participants would rarely use the word depression at all but instead would usually describe "it".

*Well, you don't notice it [depression] yourself, it's the other people that notice it.*

This comment also seems to indicate the perceived insidious nature of depression, in that it can hold control over someone without them even realizing it. Just as the above three quotes reconfirm, the use of "it", "that" or "something" to refer to their depression was very common.

The use of "it", "that" or "something" can also be seen as a way of diminishing or
depersonalizing depression so that it holds less power and control over the women. They may feel that by naming the depression or talking about it directly, it holds more power over them.

The power of depression was ultimately revealed through how it impacted each woman's life. Interestingly, in many cases the participants described their experiences with depression quite differently. When combined, the individual experiences covered a complete range of emotional, psychological, physical and spiritual effects and created a powerful picture of the all-consuming nature of depression.

Two of the participants described their depression in both emotional and physical terms but did so through the use of some medicalized jargon:

> Uh, lack of energy, lack of interest, uh despair.. Feeling that, nobody.. family or friends or professional people understand.. and then there are the physical things like loss of appetite, disturbed sleep,.. or loss of sleep (slight chuckle).

Interestingly, one woman made note of symptoms she did not have as opposed to what she actually experienced.

> I don't have.. at least as far as I'm aware.. I don't have hallucinations, or contemplation of suicide or.. or what are some of the other things that people have with depression.

Terms such as "hallucinations" and "contemplation of suicide", as well as other terms used by the participants such as "loss of appetite", "suicidal ideation" and "disturbed sleep" are terms typically used in diagnosing depression within a medical setting.

Two other women also made sense of their depression in a medicalized manner through describing what they must do to contend with the depression.

> I go to my own doctor, I got a notice in the mail.. so I phoned her about.. about going to see how my condition [depression] was. [said quite quietly]

It would appear that this participant relies upon her physician's diagnosis of depression and how she must deal with it. Through the statement, "going to see how my condition was" infers that
she is viewing her depression like a physical illness for which she consults the doctor to
determine if she is better. The assumption seems to be that she is unable on her own to
determine how she is doing. Another woman expressed a similar experience with her
depression. This woman even explained to me how she has looked up depression in a dictionary
to understand how it relates to her, thus seemingly looking for a tangible description.

The other participant described her depression in terms of its physical impact and by what
she has come to associate with the depression.

\[ \text{I don't really feel it [depression] that bad..No..it's just the headache you know..you get a} \]
\[ \text{headache. Well, I guess that whenever it comes up I go to see those doctors.} \]

The other two women described their depression as impacting them emotionally, physically
and psychologically.

\[ \text{Well you usually start off with waking up early in the morning..like around 4 o'clock in} \]
\[ \text{the morning. That becomes like..the thing to do, to wake up early. It [depression] starts} \]
\[ \text{off like that...And then you, uh, begin to lose interest in things that you like doing..and} \]
\[ \text{you, uh..just, all you want to do is lay on your bed. And uh, it just goes on from} \]
\[ \text{there...Well you stop, you stop calling your friends or you don't talk to them very much if} \]
\[ \text{they call you.. And uh, you just lose general interest in the news and the newspaper and..} \]
\[ \text{magazines and anything that you really liked before [Doris].} \]

\[ \text{Well it feels like your stomach goes into a knot and you know everything seems so awful} \]
\[ \text{that you can't cope with anything. You're scared to death almost..Ya you're very} \]
\[ \text{scared to live at all, you wish you could escape it..It's, it's a terrible feeling. I, I don't} \]
\[ \text{know,you don't sleep you can't sleep and your heart is pounding and you're} \]
\[ \text{perspiring..oh boy! You've got to change your clothes several times a day or take a} \]
\[ \text{bath, you're dripping wet [Hilda]. [emphasis original]} \]

From the above quotes we can see how much the women felt the depression took over their
whole life not only emotionally but physically as well. Passages like: "you just lose general
interest in... anything that you really liked before", "you're scared to death" and "you can't cope
with anything", gives the sense that the women felt all consumed by the depression.
The control that the depression had on these women, influenced their lives in various ways. For example one participant describes how it impacted her life.

*I tried other jobs, but I could never hold onto them long enough. I kept going in and out of depressions.*

This participant indicated her frustration over the uncontrollable nature of the depression and the impact it had on her employment situation. As described by the participants, other ways that the depression controlled their lives included: impacting what interests they held; not being able to travel when they wanted to; interfering with relationships; limiting what they could do with their children; and even controlling where they could live.

The participants had primarily two explanations for their depression. One way of making sense of it was strictly as a medical or biochemical event.

*Evidently I stopped taking my pills, so that was a bad thing to do...ya...so...uh, that was a bad mistake...so now this time I have to keep taking them.*

There appears to be a voice of medical authority behind this woman's beliefs and practices. She seems to have taken on the message that she is at fault for the reoccurrence of her depression by not taking her medication properly.

Three other participants similarly viewed depression, as primarily being a biochemical event unrelated to any personal circumstances in their lives. Although these women expressed that their depression was biochemically based, two of them did make other comments that questioned their strict adherence to this belief.

*I couldn't be sure that it [depression] was all just chemical.*

This understanding of the etiology of depression was common amongst most of the women, except for one participant who, as noted earlier, saw the potential for an experiential basis for depression, which was the second way of viewing depression. This same participant, however,
further along in the interview also indicates that she believes that there is a genetic, biochemical component to her depression

*I think, I probably inherited the tendency. Considering that both my parents committed suicide.*

In further discussions with this woman, it was revealed that the belief in the "inherited" or biochemical basis for depression is somewhat less threatening and a more self-preserving explanation. To her it implied that she could have no control over the illness, and was something that just happened to her. This notion further reinforces the idea of an unknown, uncontrollable entity. It is also less threatening because it implies that the depression can be cured. A strictly experiential basis for depression can be frightening since there is the belief that depression would not be able to be cured since you cannot change the past. I did confirm these beliefs in a follow-up interview with three of the participants.

All of the women at some point expressed the desire to not think of the past but only of the present and future.

*I don't, I just don't dwell on that part of my life [voice drifts off].*

It seemed to be a rather frightening prospect for these women to even think about difficult times and they all felt that they were better left unexplored. They ultimately did see the depression as separate from themselves and out of their control, and this was a far less threatening concept than something that they could have been a part of circumstantially.

These women's experiences of depression seemed to indicate that they felt depression was an unexpected event, came from outside of them, and held control over their lives. The theme of power was relevant throughout the descriptions of these women's experiences. First, the power of the depression itself was an overwhelming force in the lives of these women. Second, was the power of the dominant medical model evident through how the women understood their
depression and described it, sometimes even detaching from the experience. Third, was the potential loss of power due to multiple losses the women had experienced in their lives. Fourth, was the power of gender socialization in how they perceived and discussed life circumstances, preferring to minimize some significant life events.

Finding Allies

The dynamics of accepting the assistance of healthcare professionals was a critical component of understanding these women's experiences with depression and ECT. At this stage, it seems that the relationship developed between the healthcare professional and the women set the course for future interactions and treatment.

All the women acknowledged the help of healthcare professionals, however, this was not an easy undertaking for most of these women. The messages that were clearly ingrained in all of these women were that they were not supposed to dwell on or discuss their difficulties.

*It's a terrible feeling and yet I try to make the best of it and I keep a good frame of mind and I don't think you can do much better than that.*

Quiet determination and remaining somewhat stoic were admirable qualities and recognized as signs of strength by all six participants, perhaps demonstrating the importance of age specific gender socialization.

*...they didn't think I'd make it, but I did make it. I guess I'm a pretty tough cookie (chuckle).*

This participant made this comment quite light-heartedly, however, the message of being a fighter resonated quite clearly and it was a consistent one across all of the participants.

Given this strong inclination to persevere and not complain about things, it is not surprising that only two of the women sought out help for their depression on their own.

*She's wonderful. She's been a great help to me. Whenever I get really down I don't go to a psychiatrist right away, I phone [name of mental health team member].*
Both of these women have had quite a long history of depression and they admitted that it has only been more recently that they could identify when they are depressed and could actively seek out help.

The other four participants did not seek out help on their own but were identified either by family members, friends or medical professionals themselves. One participant sought help through the assistance of a friend.

..talking to a friend and a neighbour..she knew that I was..concerned enough to think that I needed to get to my doctor.

Two participants gained the help required through family members identifying that there was a problem.

\[family member's name\] tells me things that I went through..I don't know how you figure that out, because I can't [said quietly].

Finally, one woman was identified and was provided support directly by mental health professionals.

\[name of mental health team member\] helps me out..

Although the participants may not all have identified the depression themselves or sought an ally on their own, all of the women believed in accepting the help of the medical professionals.

I wouldn't do it [become well] by myself, I would get help from somewhere...I would ask my doctor or..Dr. [name] or I would ask somebody else..I wouldn't just do it on my own.

The repetition of the idea "I wouldn't do it by myself", seems to indicate an acceptance of support by choice. It is not that this woman could not do it on her own, just that she would not. Implied through this statement is that this woman is preserving her sense of self as a fighter and a survivor. Thus as was the case for all the participants, asking for and/or accepting help from
an ally is not an admittance of defeat but rather an acknowledgement that they require help from someone who may better understand the invading force.

Criteria for Accepting Help

For all of the women, accepting the assistance of an ally was contingent upon two factors. First, that the medical professional have specific knowledge. The knowledge necessary was in claiming to know and understand the outside entity, the depression, better than the participant did. The four participants who had assistance in gaining help accepted that they did not understand the depression and admittedly believed that the medical professionals assisting them better understood the invading entity.

Dr. [name], she put me on the anti-depressants. I don't know whether she saw something or whether somebody else said something... I, I wouldn't be able to figure it out... I don't know why I was put on anti-depressants. I just know I was. [emphasis original]

The two women who accessed help on their own did not as readily buy into the belief that the medical professionals understood more than they did about their depression.

That's why you go to a doctor, you do, you follow their directions. But then I mean doctors aren't god, gods. I myself feel how I am much better than a doctor can tell me [nervous laughter].

This participant made light of her comment, but it was a significant point of departure from the usual unquestioning acceptance of the authority and knowledge of the medical professionals she has dealt with. She appeared to wrestle with herself on a number of occasions regarding this belief, however, she seemed uncomfortable maintaining this position. Despite this questioning of expert knowledge, both these women ultimately conceded to respecting the necessity of accepting help.

I think, I...I have learned a little about how to cope with it. When I start feeling depressed, I ask for help from the mental health team... and they have been very good to me.
The second essential criteria, was that the healthcare professional be trustworthy. The component of trust building that appeared most important to the majority of the women was that of developing rapport with the health care professionals and liking them.

Well, I think I get along pretty well with them [doctors]. I always seem comfortable with them really.. Dr. [name] oh yes, hmmhm.. oh she's a wonderful person. Ya any of the doctors that I've had I've always gotten along with them..

This participant expresses quite clearly the importance placed on getting along well with the healthcare professional. All of the women except one, when discussing their experience of trust with the allies, expressed it in terms of liking the healthcare professional and/or being treated well by them. In response to a question regarding her trust of the healthcare professionals, one participant responded:

Well, I, I think so.. I would say.. they're wonderful.. ya...

As well, in response to asking the same participant whether she had more trust in the medical professionals if they treated her well she said:

Ya, oh yes, it pays to be treated well..

Both of these comments show the direct association between rapport building and trust which was a common sentiment expressed by five of the women. In some cases, when participants were asked about trust in the healthcare professionals, they started out discussing the importance of knowledge and abilities but usually ended up equating trust with being treated well and getting along well with the medical professional.

And Dr. [name], I mean she's a very.. knowledgeable person, so you know I rely on, I trust her .. I'm sure I get along good with her. I always feel comfortable with her... I would rely on her whatever she said. [Emphasis original]

Only one participant was very clear about trusting healthcare professionals based on their abilities rather than on the personal rapport she developed with them. In a follow-up interview
with this participant, she expressed quite strongly that she would rather have someone who knew what they were doing than someone who necessarily "said hello to me and made conversation with me each time they saw me". She did acknowledge that friendliness and rapport was important, but that ultimately knowledge and skill were the most important features for her in developing trust in the medical professionals.

Relinquishing Power

Based on the development of trust and faith in the expert knowledge that these women felt the healthcare professionals had, these women placed a great deal of power and control in the hands of the healthcare professionals. The last quote in the previous section is a very good example of just what kind of power is given over to the healthcare professionals who help these women. The comment "I would rely on her whatever she said" reveals the depth of power and control that this healthcare professional wields in the life of this participant. This power and control was an undeniable part of all the women's experiences with seeking allies and was evident in many examples of their comments when speaking about the medical professionals they dealt with.

I had a very nice psychiatrist he, his office was in [health region] and I was under him and he prescribed my medication in the ward.

The power differential between the participant and the psychiatrist is clearly evident through comments like, "I was under him". This power over dynamic is not necessarily assumed but granted to the doctor.

An outcome of this process of giving over power to the healthcare professionals was that any subsequent consent process became pointless and/or meaningless to them. The formal informed consent documentation meant very little to these women since they felt they had already given over their trust and power. All but one of the women either did not remember signing an
informed consent form and/or did not care whether they signed something or not and none could iterate what rights they had in relation to the treatment, such as terminating the treatment if they wished to.

*I don't remember signing a consent ..I, I probably did but I don't remember it..Uh, I trusted them.*

Here again we witness the importance of trust and the giving over of power in the process. Although, this participant admits that she does not remember signing an informed consent form, she also implies that it was not important in the process of seeking help for her depression. What was important was the trust, which was given implicitly.

*Anyway..you get, you get your consent from your own doctors you've had for years to see if it's necessary to go [for ECT treatment]..*

This participant clearly states that she expects that her doctor will make the decision for her to have treatment, she does not see herself as having that choice. Here again we see the use of the second person "you" "your" and "you've" to describe her experience in decision making power. This shows a distancing from the process, which seems to further reinforce the position that power is given over to the physician in order to combat the depression. The use of generalized terms also seems to demonstrate the prevailing assumption that this is a normal decision making process.

Only one woman clearly remember signing an informed consent form and even she was rather indifferent about how important it was to the process.

*I remember way back when I was given something to sign..and that was a long time ago..so.. that's all I can say..Well I think I was satisfied that I was willing to sign the consent form.*

This participant's willingness and acceptance of the process is acknowledged through this statement. In her mind, the trust and power had already been granted upon the healthcare
professionals prior to this formal agreement. This participant's attention to detail was evident throughout our interview in the precise way she spoke, the information she shared with me and the detail to which she reviewed the transcript and provided valuable feedback. She was the only one who really remembered the informed consent process and yet given her attention to detail it was all the more surprising to me that she spoke of it so lightly. Her rather nonchalant reference to the informed consent process seems to show it to be a rather uneventful process for her, an idea that was later confirmed in a follow-up interview.

Common to each woman's experience of conditions of getting help from allies then, was the trust in the healthcare professionals based on a combination of rapport and expert knowledge of the invading force. Power was again the central theme of this discussion with the development of the trust and power dynamic between the healthcare professionals and the women, with the giving over of control by the women. Power was also evident through the power of gender socialization reinforcing the agreeable and cooperative nature of most of these women. Detachment from experience was once again witnessed through distancing language used. As well, the use of dominant medical discourse to describe experience was apparent through the strict acceptance of the medical profession's descriptions of the problem.

The Rescue

At some point during the course of their depression, ECT became the requisite treatment method for all of the participants. ECT can be seen as a required method of treatment because, as previously discussed, all of the participants believed that they had given over their trust and power to the healthcare professionals treating them and by doing so they no longer had a choice in the matter of treatment.
...it [ECT] was just something that you had to go through [resigned]. Well they came for you and that was that. You couldn't, what could you do? You had to go. But I don't remember having been asked if I wanted it done.

The specific use of phrases such as "you had to go", "they came for you", and "what could you do" emphasize the clear lack of control this participant felt in regards to receiving the treatment. Within this passage we once again see the frequent use of "you" to speak of her experience with ECT which seems to distance herself from the experience. This use of the second person to describe ECT experiences was, once again, common to most of the women at some time or another.

When I had asked others about treatment options presented to them they all expressed quite similar views that they were not really given options, but instead were advised as to their course of treatment.

*Well...they don't present it to you like that, but they do...their best to..by changing medications or you know..altering the dose or trying something different..They try to, uh..control..the medication..I think they use ECT as sort of a last resort.*

This woman's use of the statement, "they don't present it to you like that. But they do their best" expresses that she really is not presented with options to treatment but that it is okay with her since she has already entrusted her treatment to the medical professionals. Her use of the word "control" is a power laden term which connotes the authority she feels the medical professionals have, possibly even over herself. Finally, her uncertainty in saying "I think they use ECT as a sort of a last resort" shows her questioning of the situation but not one that overtly questions the authority of the doctors. Three participants cited the idea that ECT is used as a treatment method of last resort. Interestingly though, none of these same participants necessarily felt that it was used as a last resort necessarily in their case. What they actually believed was not that ECT was a treatment of last resort but rather that it was faster acting than medications.
I know the shock treatment works the fastest...

Quite similarly, these three women also cited other rationales for using ECT that come straight out of biomedical research in the field such as:

..because most of the medications have side effects  [Hilda]

*Specially with older people cause it ECT seems to work quite well with older people..* [Margaret].

It was interesting to see how these women had absorbed this medicalized information to make sense of their own experiences.

Furthermore, none of the women questioned the idea that the use of ECT as a last resort was inconsistent with their realities of being on anti-depressant medication. This incongruity was not addressed by any of the women and instead seemed to be an accepted fact of their lives that medication and ECT would be almost interchangeable at times.

*Because, it, it's uh, you can be on medication forever and sometimes it doesn't help much and sometimes it has side effects... it ECT works quick, comparatively quickly compared with medications.*

All the women reported being on medication regardless of whether or not they were currently receiving ECT.

*Oh yes, I've been on scores of them (anti-depressant medications) before, it's uh, Dr. [name] put me on Paxil. And the ones I had before, oh several of them, well at the very beginning I remember what they gave me was uh, valium.*

This comment highlights the familiarity with which most of participants were with psychoactive medications. In fact, none of the participants seemed to feel that it was particularly surprising that the two treatments would be done simultaneously, or that it may be difficult to tell which treatment was actually having the biggest effect on the depression.

**Descriptions of ECT**

None of the six participants could remember a great deal about their ECT treatments.
"I don't remember too much about it, I just don't recall."

Sometimes rather than remembering exactly what happened to them, some of the participants would remember specific associations that they had made with the treatments. For example, one participant quite clearly recalls the process of having the oxygen mask placed on her as well as the anaesthesia being given.

"Ya, and, and the feeling when they put the needle in you, you start feeling like you want to throw-up. And then they cover your mouth and you feel like you're choking [emphasis original]."

Two other women also noted an association with the process of receiving the needle for the anaesthesia.

Another participant had made a very strong, negative association with one particular treatment she received at a hospital in a specific region.

*My glasses were taken off and my teeth. But I didn’t see whether the teeth were put in something with my name on it or anything. And they put me in just as I was [pointing to herself, with clothes]. Slacks, blouse, in [name of hospital] you take all your clothes off and you're put in a gown plus a diaper. And they put me in like this for a treatment?! I'll never forget that, I wouldn't ever go back to that hospital for anything!..When you're being put to sleep and having a treatment of any kind, you could lose control of your bladder or your bowel even. Now wouldn't that be nice in your clothes that you leave there with! Doesn't that, that's disgusting! [said in a sarcastic voice with emphasis]*

Interestingly, she remembered many more details of this treatment than she did of any of her other treatments. She clearly reacted to the vulnerability and disrespect she felt she experienced in this situation. What is also noted through this account is that this participant expresses much more comfort in being treated within a more formalized medical environment where she must wear a gown and diaper. She seems to feel it is more respectful and she obviously has more faith in that approach.
Other strong associations the women had made and described in relation to their ECT experiences were: being moved on the stretcher; the routine of travelling to the location for the treatment; the placement of the electrodes; and waking up after the treatment.

Four women described their ECT experiences according to the specific physical procedure they went through.

I just remember being moved on the stretcher...uh...and that they told me that...uh...they'd be giving me the injection and that I'd go to sleep very quickly, which I did...And...really it wasn't anything to...to be afraid of or to worry about.

This participant in describing her experience, interestingly switches back and forth between what she actually experienced and what she was told she would experience. This practice could shed some speculation upon her final comment "it wasn't anything to...to be afraid of or to worry about" whether those are actually her words, or if she is reiterating a comment made to her.

Integrating their personal experience with what had been described to them by medical personnel as the procedure was common to all of the women's descriptions of their ECT experiences.

Two of the four women, rather than actually describing their own experience, retold precisely what procedure they had been told they would go through. One woman described ECT this way:

Umm...well, I, I think it was probably described as what the physical process would be like. That, you know I would be...given an anaesthetic prior to the..ECT.. And that I would receive a..mild electric shock which I wouldn't..know because hopefully the anaesthetic would be successful..and it has been (chuckle). And that shortly after I would recover and...in a recovery room and...get something to eat and uh..might feel..drowsy, and usually and that I would uh the hospital would feel reasonably, if I was having maintenance ECT and leaving the hospital, um..that someone..if, if I were somebody who lived alone I would need to have some other person responsible for me til 24 hours later.
When asked specifically what they experienced they both just reiterated that they experienced exactly what they had been told by medical professionals they would experience.

Well, I, I don’t think I felt anything other than what I just said it [ECT] is.

One woman described her experience of ECT in both physical and emotional terms. She described an extremely emotion laden experience.

_I was petrified of when they, you know, put this mask over your face, you feel like choking, it’s an awful feeling... Ya, and I felt every time I had one I felt terrified but then I thought you know this is the only way I’m going to get out of this depression._ [emphasis original]

This participant's description of her ECT experience was by far the most impacting. Given her unsolicited use of words like "petrified", "awful feeling", "you feel like choking" and "terrified", it is surprising in many ways that she is as optimistic as she is about the use of ECT.

_Well I was all for it [ECT] because I thought it was going to get me out of depression. And I’d do anything or have anything._

As this comment explains, she believed that the ECT was going to rescue her from her depression. The dynamics of power and trust in the medical professionals is clearly at work here. Despite her fear of the process, she still trusted in the doctors enough to go through with the procedure and believed that it was the only thing that would help her.

**The Impact of ECT**

There were a number of cognitive, physical, emotional, psychological and even spiritual effects of ECT that were highlighted within the conversations of the participants.

The cognitive impact reported quite consistently, dealt with the disruption of memory as a result of ECT. As referred to earlier, none of the women could remember a great deal about their own ECT treatments, despite the fact that some participants had received as many as 70
treatments. One might say that this was a function of memory, however, only one of the participants reported that she felt that her memory was permanently effected by the ECT.

Yes, memory loss..I, I noticed that after the first time I had it [ECT]..it [memory] seemed to improve..gradually. But..after this last time, it hasn't been the case.. And I don't mean just, uh, silly little things like forgetting people's names and going to dial a number and then just stop and go back and look at it again, or..uh..mixing up words. It's umm..sort of missing chunks.

This loss was no small matter for this woman. She went on to note the embarrassment she felt due to her memory loss and the problems it had created for her such as misplacing and being unable to locate some rather expensive items.

Three other women reported what they believed to be a short-term impact on their memories.

Oh the memory, well..I mean..your memory's bad for awhile. It takes a few weeks before it gets, starts getting better.

Although, these women initially reported that they felt that the memory changes were only temporary, two of them later made comments which seemed to reveal that the effects were not just transient. However, these effects were minimized. The same woman went on to say:

But your memory doesn't make you feel sick or it doesn't make you tremble or anything. It's just that you don't remember things so much. You have to write down everything to try to remember (chuckle)

This participant seems to have contradicted her earlier comment through this statement, however, she seems to express that memory is not a huge price to pay for relief from the depression.

Two women did not believe their memories had been impacted at all.

No, it's [memory] fine. ..It [ECT] hasn't affected my memory.

Nor did they believe they had any problems with their memories.

..well it's pretty clear, my memory's pretty clear
These same two women during our conversations, said to me on several occasions that they could not remember some details of their lives and numerous details surrounding their experiences with depression and ECT. This seems to indicate some problem with memory function, but from what specifically I could not comment on.

What was an interesting finding in relation to this discussion was that all of the participants, while discussing any memory loss which may have been associated with the ECT, made comments which implied that the memory loss could well be the result of aging rather than the ECT.

*I'm sure it's partly aging [Margaret]*

*Oh, it's just my age I guess [Peggy]*

*..another thing I'm old. I'm 81 years old what can you expect? I think I do okay for my age. [Hilda] [emphasis original]*

This is could be seen as an example of structural inequality and the power of the myth of aging within our society. Cognitive losses such as memory have become overly associated with aging, with these stereotypes being perpetuated through the medicalization of aging. It may be less threatening to these women to accept memory loss as being the result of aging as opposed to being from the ECT.

Three women reported experiencing physical side effects. Those noted were things like headache, dizziness or a fuzzy feeling in the head.

*But I did have quite a bit of dizziness and a..a funny feeling in my head and like I told [name of mental health team member], that I've lost since I've been this long without treatment.*

In terms of the perceived emotional impact of ECT, three women reported varying degrees of negative emotional reactions to having ECT.
Well it's [ECT] not pleasant... It's not pleasant no, but... after all they put you out and that's it... Well... having something done to you like that isn't pleasant.

This participant seems torn between minimizing her own sense of discomfort with the process and expressing her dislike for the treatment. It is almost as if she is unwilling to be perceived as complaining about the treatment. Another participant also had an emotional reaction to receiving ECT. Her concerns centred on how extreme she felt the treatments were, how disruptive she felt they had been to her life and her concern over being put to sleep so many times.

Yes I am! [concerned about ECT] I mentioned it uh, when I mentioned it to [mental health team member] she says, "what's wrong with it". I said, "I don't think it's healthy". And I don't think it is either! [emphasis original]

The psychological impact of ECT is highlighted by comments three of the women made regarding the stigma associated with mental illness in general, depression and ECT.

I meant the stigma I might have had to face returning to work as a... depre... as a hospitalized mental patient... I gather that ECT, ECT treatments maybe regarded by some people as... much more drastic a treatment than pharmaceuticals and therefore indicating maybe a more drastic problem that... seems to require the use of it.

These women were concerned about how others would view and treat them and so rarely spoke about their treatments to people outside of their close friends and family members.

I, I don't... um... offer to tell them [about her experiences] unless they ask me. And if I can see that it's upsetting them I just... skip it (nervous chuckle)

The stigma of mental illness and their treatment was a very real concern for these women. It seemed that the consistent way of dealing with the potential of being judged or rejected was to just not talk about it as this participant describes, thus denying their experiences once again.

The seemingly spiritual and/or possibly psychological impact that ECT has was noted by one woman in an interesting comment she made regarding how she had felt after finishing her course of ECT treatment.
Well, I am confused as far as I'm concerned, I feel I've had something taken from me, and I've said that to [family member's name]. She's the only one that can really talk to, and understand each other. And uh, I can't figure it out either... But I still feel I've had something taken from me. But I'm trying to get rid of it [this feeling].

What do you mean taken from you? Can you describe that for me?

Well I mean I used to enjoy so many things, and I never had any..uh.. ugly thoughts about anybody, or ever wanting to get even on anybody or whatever they call it today, I don't know. But I never had any of those feelings, I don't know what they call depression.. Well [family member's name] thinks that, if I hadn't had the treatments... that I might not have been able to take care of myself, now, which I can. I have the apartment, it's my own, I can go down to the lobby anytime I want, read the paper or talk with the people. [emphasis original]

This woman seems to describe a loss that is somewhat akin to an existential crisis. She could not completely specify what she experienced as being taken from her but it is almost as if there has been a loss of a sense of herself or meaning to her life. There is a sense that in order for her to remain independent and living the life she wished to, she had to go along with the diagnosis and treatment, but in doing so she lost a part of herself. This participant was clearly distraught over her experience and her emphasis not on loss but on having something "taken" from her could be indicative of a sense of powerlessness in the situation.

After ECT

After having ECT, all the women reported in to varying degrees that they found it helpful.

I know it's [ECT] the only way to get out of my depression.

Four of the participants had ECT in the hopes of being free from depression.

It's better than being depressed for months.. And I wasn't afraid.. because I, I was so miserable I thought anything could be better. [Emphasis original]

This participant highlights the sense of frustration and desperation which was similarly experienced by four of the women which led to them having ECT. To them, the misery experienced as a result of the depression was worse than any fear they may have over the ECT.
The other two women who received ECT, did not necessarily identify that they were being freed from depression as much as going along with what they felt they had to do. When I posed the question how did this participant feel about receiving ECT, she responded with:

Well..it's [ECT] alright..I guess it's doing me some good [uncertain]..I don't know, I guess it's more what they tell me, you know...

The tentativeness in her tone and choice of words belied her answer. She may not necessarily believe that the treatments helped her as much as she believes in what the medical professionals tell her. Further along in the interview this same participant when asked whether she believes she will feel different after this course of treatments, responds with:

[pause] Well, I guess I will. ..they insist I go back.

Here again the tentativeness with which she answers and the use of "I guess I will" seems to indicate that she is not entirely convinced if or how she is being helped by the process. However, ending with "they insist I go back" clearly indicates that despite how she feels about the treatment, what matters is that she go along with what has been recommended to her. In the case of these two participants it seems that they are going along with whatever is endorsed by the medical professionals, so that they can be free to live their life as they choose to.

The ECT experiences of the women varied from extremely emotionally impacting to rather uneventful with a range of cognitive, physical, psychological, emotional and even spiritual impacts noted in the women's descriptions. The power of the healthcare professionals was, once again, predominant in the discussion of the decision-making and treatment process. Also evident was the power of gender socialization through minimizing experiences and structural inequities, which were revealed through the women's acceptance of age related stereotypes pertaining to memory loss. The distancing from experience and the medicalization of the ECT experiences was also relevant to the discussion.
The Journey Home

[very long pause]I'm a..sssurvivor, but not a happy one (chuckle). I would like..to... make a much more rewarding..life of whatever is left...

These women, as expressed by the above quote, truly are survivors. The seemingly simple desire expressed by all of these women was to live a peaceful and full life, free from depression.

..I mean, you know, you just look forward to..just continuing in some kind of good health..which is the main thing isn't it?

The tentative and questioning nature of this comment highlights how this and all the other participants do not seem to know what to expect of their lives any more.

Will the Battle Ever End?

Four of the participants fully acknowledged that their battle with depression would be ongoing and that in relation to treatment there were indignities that one had to put up with and one of the women expressed it this way.

*Well, in the perfect world, well maybe we wouldn't have ECT in the perfect world. In the perfect world if we still had ECT, we wouldn't have the gluey stuff..but I can live without that change.*

Interestingly, she did not say that in the perfect world maybe there would not be depression rather than just not ECT.

Four of the participants are not currently receiving ECT treatments, but as noted their battle with depression is not necessarily over.

*Well I mean I've got a lot of pills to take against it [depression]..so hopefully..it'll work out..*

This comment highlights the ongoing struggle for this woman and what she feels she must do to prevent the depression's reoccurrence. Two other participants, since our initial interview, have once again been actively treated for depression through medication, also indicating the continuing struggles with depression these women experience.
Two of the women are still currently receiving ECT for depression.

*I don't ponder it [the use of ECT] too much you know, I've been..grateful enough that I have had treatments that have been..helpful. Obviously you know, I've had some lapses..but um..now..maybe we're on.. a path where maybe they'll be successful with maintenance. A maintenance strategy.*

This participant's use of the statement "I don't ponder it too much", and term "grateful" seems to indicate and unquestioning acceptance of the treatment. Through this comment she seems to blame the reoccurrence of the depression on herself, "I've had some lapses" and the successes of treatment on the medical professionals "maybe they'll be successful with maintenance". At a number of times during my conversations with this participant, she expressed how "grateful" she was for the life she had in comparison to others lives. The dominant socialization messages and even medical discourse she has imbedded within her seems to indicate that the burden she has to bear is minimal compared to others and so she should just put up with a little inconvenience and be grateful for the outcome. This same type of message was expressed by all of the participants in relation to their ECT experiences.

Several elements of power and trust are visible throughout the statements made by the women in relation to their ECT experiences. The idea of unquestioning trust relates to the idea that once you have asked for and/or accepted help from people, you do not question their abilities or methods overtly. Here again, not complaining became a virtue and a sign of a strong person.

*I, I don't know, maybe she, she won't like it if I don't do things the way she..you know, she tells me to do. That's what you go to a doctor, you do, you follow their directions.*

This quote quite eloquently describes the belief system held by the participants, which is that it is not right to question the judgements of the medical profession, particularly when you are being helped. The fear of the reprisal or, as later expressed by this same participant, that the
medical professionals will not be willing to help you again is a very strongly felt threat to these women.

Would They do it Again and Would They Recommend ECT

There was the unanimous opinion expressed that ECT had helped them all in some way and that they would all have it again if it was necessary. Although two of the women could not determine exactly how it had helped them.

*I suppose in some ways it's helped me.*

This participant's comment is tentative and indicates her uncertainty as to how the ECT has helped her almost as if it is something she feels she should say rather than wants to say.

Despite some uncertainty all four of the women no longer receiving treatment said they would have it again if it was necessary, albeit begrudgingly for at least one participant.

*No, I don't see the point of having any more of those [ECT treatments] right now...Well it just depends how bad you are. I mean you have to do that because how are you ever going to come out of it?*

This participant makes a quick switch in perspective seemingly indicating the fight that she has within herself over the topic.

Even though, all of the participants acknowledged that they would have ECT treatment again if they became severely depressed, only one of the participants was entirely positive about the prospect. One woman, despite or maybe as a result of, still being in the process of treatment, remains steadfastly positive and optimistic about the treatment.

*Well, I guess I've felt..more than grateful that..I'm one of the ones who can..look at it positively.*

Of the six participants, two participants were unwilling to say whether or not they would recommend ECT as a treatment to someone else. They did say, albeit hesitantly that if they needed it again they would accept the ECT with reservation.
.. like I've told the doctor, I don't want to spend the rest of my life, going through that [ECT]. And I am really pleased that I'm off of it. But if somebody else needs it, that's fine. But I think I must have had quite enough of it. [emphasis original]

In this participant's case, her acknowledgement of the ECT's potential help may not be as much an admittance to the treatment's effectiveness as a justification to herself for spending so much time and effort doing something that she did not originally believe she needed. She is however, quick to not generalize her experience and not to criticize others for wanting the treatments.

And anybody that needs it, good luck to them! But I'm glad I'm finished with it if.. possible... I mean I don't mean to recommend it to anybody. Uh, if the doctors know what they're doing. [emphasis original]

Despite her strong words, even she is careful to admit that she ultimately feels that she does not have the control. In her statements she still refers to the doctor's authority and only says she is finished with ECT "if possible". Her questioning of whether or not "the doctors know what they're doing", could be a questioning of physician's judgements regarding the use of ECT, or it could be a cautionary note to others when contemplating treatment. It is difficult to determine this and could actually be an indication of her own internal dialogue on the issue. Ultimately, she also sees herself as a survivor through it all and, as previously noted, that is an admirable quality in her mind as well as the others.

Well I'll tell you what and all.. I just got..stronger, I guess.

Two participants were very clear that if they felt desperate enough they would accept any treatment that could be offered to them and would recommend it to others for depression.

If I'm really desperately depressed, I'd do anything to get out of a depression. Whether it's uh..medication or whether it's shock treatment. But I know the shock treatment works the fastest.

As previously noted, one of these women openly admits that there were repercussions to the treatment, which were as she perceived, permanent memory loss.
I hoped it [memory loss] wouldn't last this long. You know, they tell you, oh it will come back in time..but I find it doesn't.

This was a very disruptive impact for this participant and one which she expressed a great deal of concern over, however, she was still willing to accept this cost over her emotional pain.

Another participant when asked what she would do if she became depressed again replied:

Well..um..medication and counselling, but..if I got to the point where I was desperate and it was like last year, it definitely wasn't helping, then ECT again.

Comments made by both of these participants indicate that they would accept ECT again if they became "desperately depressed" again. A qualitative determination of what constitutes "desperately" was not clear. Quite realistically, ECT is not the first choice for these participants but it is certainly not without careful consideration.

Another participant would also accept having ECT and without the same necessity of desperation expressed by the other two. Although this participant expressed fear with the process, she truly believes it worked for her and she would do it again if she had to.

..for some people maybe the medications work, work better than for others, or maybe the find, a medication that suits maybe for me better than it would for you. So that's how it is, but, the only thing what I found was when you are really deeply depressed it's ECT that helps.

Her testimonial is carefully said and she recognizes that it only applies to her, which she is quick to point out.

The Role of Alternatives

There appears to be little room for other types of therapies such as counselling, allowed for within the above discussed ideology. In fact, most of the women had never had counselling, or had it very sparingly and seemed to indicate that they were uncertain as to its effectiveness.

That [counselling] helps to a certain extent, but it doesn't really get you out of your, your, my depression.
Through further inquiry it was determined that other reasoning was behind the decision to pursue counselling or not.

*It [counselling] doesn't work as quick as ECT.*

Here again we see the valuing of the speed of response over and above other qualities.

The significant role of medicalized emotions and disconnection of experience becomes highlighted in this discussion of alternatives. As previously mentioned all but one of the women made no significant link between their personal life experiences and their emotional state. They all primarily saw the depression as being biochemical or in the case of the two women who did not identify themselves as being depressed, some not quite determined event.

*I don't know what it is, I can't explain it.*

The significance of such a profound disconnection between each woman's emotional state and their life interactions was captured by how unfamiliar the women were with describing their experiences or even being asked about their experiences.

*I knew that the interview was about depression in older patients and the use of ECT and how they felt about it. I did not realize it would cover most of my life history. I think you have heard more about it than most of the professionals.*

The above comment was the most pointed one on indicating surprise at being asked about her life. Three other women also made similar comments as to their surprise at being asked about their life. All indicated that they had a hard time speaking about their lives for they had never really been asked much about it before. Along this same vein of understanding, this same participant made the comment during the interview.

*Perhaps earlier..uh..if with the first psychiatrist that I saw only briefly, if there had been time to do that [talk about her life], it might have made a difference.*

Instead, there seemed to be no time allotted for in-depth discussion of emotions, thoughts or life events within their experiences, little time for talking at all.

87
...they [mental health team] tend to focus on the present.

As noted, there is an understanding expressed by all of the women that their struggle with depression may be an ongoing one. For three of the women, this idea was more hesitantly spoken of.

*It's [depression] a terrible feeling. You wonder what's going to happen next. But I've come out of it...all...hopefully. That's all I can say.*

The hope is clearly that this participant will remain well and she really does not want to talk about any other possibility.

For the others, there is a graver understanding of the potential of their continued struggle since they have already had quite a long history of depression.

*I would like.. to..uh.. make a much more rewarding life of whatever is left.*

This rather painful comment highlights the culmination of a nearly life long struggle with depression.

Despite this, most of the women remained quite optimistic about their recovery and often expressed thankfulness for what they did have and frequently compare themselves with others they see as being less fortunate.

*Well, I would think when you look at some other people, it's been pretty good actually. Just for this last..part of the..of the depression [somber voice] hasn't been that good, but I think I've had a lot of good, a lot of help from different people..ya, you get lots of help.*

Through this comment it appears that this woman may be grappling with some mixed emotions on the issue. By saying "I would think" she is intimating that she feels that she should be thankful but maybe is not quite convinced. This comment may also portray the power of gender socialization of minimizing her difficulties and instead, being thankful. The message of not dwelling on the bad things but instead move on is a common message amongst all the women.
Despite how each of the women experienced their depression and ECT, there was consensus that they would have the treatment again if it were necessary to do so. However, the women did differ in how willingly they would accept treatment again and whether or not they would recommend it to others in a similar circumstance. A predominant theme of power was highlighted through the impact the women's interactions with the healthcare system had on their view of self, their future health and the potential for alternative approaches to treatment. There was also a disconnection between these participants' life circumstances and emotional responses, which was reinforced by the power of the dominant medical model. Finally, there was the understanding by some of these women that the depression could be an ongoing struggle for them, but the hope and desire of all was to live a peaceful life free of the invading entity.
CHAPTER 4
UNDERSTANDING AND INCORPORATING
THE EXPERIENCES OF OLDER WOMEN

There was one over-riding theme that emerged from this research project which gave rise to two other important insights. The primary theme which arose from the data, was the many dimensions of power that played out in the experiences of these women. The most conspicuous dimension of power relevant to the depression and ECT experiences was the control wielded by the medical professionals in the lives of these women. Implications from this are the impact on the informed consent process. A second point, which stemmed from the impact of the power held by the medical professionals, was witnessed by how these women appeared to disconnect or distance themselves in various ways from their experiences. The third revelation, resulting from the power of the healthcare system on the lives of these women was the power of the dominant medical discourse that characterized these women's experiences.

The narratives of these women's experiences developed in a four part, metaphoric journey that could be described as an alien invasion experience. The four parts being the invasion/becoming depressed, finding allies/conditions of getting help, the rescue/the treatment and the journey home/hope for recovery. This chapter will discuss how the findings from this journey complement and provide new ground for understanding the role power plays in the experiences of depression and the use of ECT in older women. Furthermore, through the use of feminist and empowerment oriented social work theory, theoretical and practical ideas will be developed from these findings which could help foster changes in the healthcare system to better honour the experiences and meet the needs of older women.
Dimensions of Power

The key finding of this research project was the overwhelming and undeniable role that power played in the lives of these older adult women. The findings highlighted at least five issues of power, or more specifically loss of power, that were relevant to the experiences of these women. These dimensions of power were:

1. The power that depression held over these women.
2. The lack of power experienced by these women due to structural factors.
3. The lack of power resulting from multiple personal, physical and emotional losses.
4. The power of age specific gender socialization in the lives of these women.
5. The power held by healthcare professionals in their lives.

First, through the findings it was revealed that these six women felt that the depression was a very powerful force that controlled their lives. Schreiber (1996), in a grounded theory study of women's experiences of depression found, quite similarly that the women she interviewed often saw their depression has having power over them. The women described themselves as losing control of their lives and being unable to stop the process. Schreiber termed this phenomenon "Seeing the Abyss", and saw it as a phase of the women's depression (Schreiber, 1996, p.4). For the women I interviewed "Seeing the Abyss" seemed to play a constant role in their lives, since depression is reoccurring for them and thus limits the amount of control they feel in their lives.

The second issue, is the lack of power experienced by these six participants due to structural inequalities. Common to all of the participants was their lack of power by virtue of being older women suffering from mental health problems. There was no overt acknowledgement by any of these women of experiencing this lack of power, however, they all in a subtle way expressed its impact. What was revealed by all of the women through their comments was an acceptance of
ageist stereotypes, in relation to memory loss. As noted, ageism is insidious and can facilitate the devaluing of one's self, leading to greater incidence of mental and physical illness (Grant, 1996). Also expressed by several of the women was their concern about being perceived and treated differently due to the stigma attached to mental illness. These stereotypes definitely played a role in how these women viewed their own personal circumstances, what impact they perceived the ECT to have on them, and how and to whom they spoke about their depression and treatment.

A third component is the lack of personal power related to experiencing multiple losses in one's life. Cox & Parsons (1994), describe powerlessness as an interactive process between a person and their environment that creates a sense of hopelessness and vulnerability. They go further to say that this loss of power is characteristic of older adults because of the multiple personal losses they have experienced due to physical decline, illness, loss of loved ones, economic vulnerability and some socio-political factors. All the women I interviewed revealed a plethora of significant personal losses, thus leaving them emotionally, psychologically and circumstantially vulnerable.

A fourth element of power, was the quite well ingrained power of gender role socialization that guided the ideologies and discourse of these women. As noted in the conceptual context, women over the age of 65 were raised in an era that strongly reinforced the messages that women were to be passive, cooperative, amenable, not question authority, put up with difficulties and not complain (Huggan, 2001). As revealed through the findings, these women certainly engendered those qualities, and those beliefs guided their interactions in their lives in general, and specifically within the healthcare system. In interactions with the medical system, older women have been found to be more passive, ask fewer questions than their younger
counterparts, and often allow their doctors to make treatment decisions for them (Beisecker, 1996). The strong influence of this age group's gender socialization may result in them being reluctant to voice concerns or even disagree with healthcare providers regarding their treatment.

The fifth dimension of power, which was most relevant to this specific project, is the power of the medical profession in the lives of these women. The control held by healthcare providers has many implications, one of which being the effect this differential power has on the process of informed consent. This will be discussed at length because of its relevance to this study.

Two other implications that arise out of this issue of power of the healthcare professionals are the instances of disconnectedness from experience which the participants displayed, and the power of the dominant medical discourse that was evident.

The Trust and Power Granted to the Medical Profession

Trust in the medical professionals was necessary for these women to accept help. For most of the women, trust was based primarily on building rapport with the medical professionals and being treated well by them, rather than on perceived abilities or knowledge. Measures of friendliness, and liking have been found in previous healthcare research, to be key components for medical professionals developing trust and obtaining compliance from patients (Fitzpatrick, Hinton, Newman, Scambler & Thompson, 1984). Based on the development of trust/rapport with the medical professionals and the belief that these professionals held expert knowledge regarding their depression, these women gave over their power to the medical system. Age related gender role socializing may also have been instrumental in facilitating this transfer of power to the healthcare professionals.

One of the main issues, which arises out of this transfer of power and was a common element to all of these women's experiences, was the informed consent process required for
ECT. Although all were treated as voluntary patients, only one woman remembered the consent process and none of the women felt it was a very meaningful process since they had already given over their power by virtue of their trust.

McCullough (1999), comments on how the change to a highly medicalized and managed care model has increased the power and influence physicians exert over their patients. He questions whether doctors have the "moral authority" for the power they exercise in the lives of their patients (McCullough, 1999). This holds specific implications for the process of voluntary informed consent for psychiatric procedures.

Is Informed Consent Truly Voluntary?

Autonomy, beneficence, nonmaleficence and justice are the basic concepts that govern biomedical ethics (Abrams, 1997). In other words that medical care is self (patient) directed, is beneficial, does no harm, and that it is applied fairly and equally. These ethical principles are applied to ECT and used to validate its use (Abrams, 1997). According to this ethical standard, the process of informed consent meets the requirements for autonomy. Literature that supports the efficacy of ECT satisfies the requirement of beneficence. Research that indicates the minimal cognitive and memory effects of ECT meets the requirement for nonmaleficence. The issue of justice is a harder one to fulfill, but is also usually satisfied by the fair and equal application of treatment as a result of the informed consent process (Abrams, 1997).

Interestingly, my research could challenge many of these ethical principles when applied to the ECT experiences of the women I interviewed. For example, the negative experiential comments made by some of the women about ECT could challenge the nonmaleficence clause. This same argument has been used by others to challenge the ethics of ECT, particularly in the case of
nonmaleficence (Breeding, 2000). However, my main challenge is levelled at the issue of autonomy and its requirements being satisfied through the process of informed consent.

The process of informed consent is a critical issue pertaining to ECT and psychiatry in general, since individuals involved are seen as being extremely vulnerable (Breeding, 2000). Except in the cases of involuntary treatment, it is essential that all individuals receiving ECT sign a consent form (Abrams, 1997). This is the same practice that would be followed if they were receiving any other medical procedure. To add the dimension of competency, Moye (2000) asserts that an older adult's competency is less likely to be questioned when she or he concurs with the treatment proposed than if they do not. Beisecker (1996) found that older women readily give over health decision making power to doctors, further supporting the lack of control the women have in the process. According to Abrams (1997), the process of informed consent involves:

- A full explanation of the procedure in understandable language.
- A discussion of the possible risks and benefits of the treatment as well as compared to alternative therapies.
- A statement to the effect that a person may withdraw their consent at any time and for any reason.

It is also quite common for individuals to be shown an educational video which will further describe the ECT procedure (Abrams, 1997), which is a practice that is common locally in Regional facilities.

All the women I interviewed would have gone through the informed consent process prior to the first time they received ECT. However, as noted in my findings, most of the women did not remember the process nor were they concerned about whether they had been a part of this
process or not. All of the women did not really feel they had a choice in the treatment process, nor as the informed consent process allows, did they think it was really within their power to stop having the treatments. As a part of the process of getting help, all of these women in some form or another made comments that indicated a sense of giving over their power to the healthcare professional prior to receiving treatment. This is despite attempts, such as the informed consent process, to convey a different understanding. As discussed previously, trust and rapport developed with the medical professionals prior to treatment meant that by the time they were to sign a consent form the process was insignificant. They had already given up their power and ability to act autonomously and consent voluntarily. The essence of autonomy in its application to biomedical ethics in the case of ECT, is being of free will to direct one's treatment (Abrams, 1999; Breeding, 2000). Given these women's numerous expressions of powerlessness in the healthcare setting, can these women truly be seen as being able to provide voluntary informed consent for this treatment?

Breeding (2000), uses this same line of reasoning to challenge the ethics of the process of informed consent. He asserts that individuals fall victim to this process at a time in their lives when they are extremely vulnerable and looking for support. "Their only hope, in this desperate state, is to trust the wisdom and guidance of the professionals to whom they turn for help" (Breeding, 2000, p.67). In the case of the participants in my research, I would further add that given the aforementioned structural inequalities that place older women in a very disempowered position within society in general and within the healthcare system specifically, these women were even more vulnerable and disempowered within this treatment process.

The issue then becomes one of lack of power and choice. If these women are given a voice and empowered in the process would they still consent to ECT? The women participating in
this project when asked if they would repeat the process of ECT generally indicated they would if they needed to. This could be construed as giving voluntary consent? However, these same women also expressed that they felt they had no other choices. It may not be enough to just alter the balance of power and what we conceive of as voluntary consent, we need to further examine what choices are made available to these women. This concept will be further detailed through the implications for change section.

The Disconnected Self

A very interesting finding that arose out of the research process was the sense of detachment from experience that the women conveyed through their discourse and beliefs expressed. For the purposes of this discussion, I have termed this occurrence the disconnected self. What I mean by the disconnected self is that the women who participated in this project were in some way quite detached from parts of their life experiences, their emotions, their experience of having ECT, and/or their sense of self.

According to illness experience literature, this sense of detachment is influenced by the women's interactions with the medical system. Lacking control and power over one's self in a medical situation can facilitate a disconnection process (Frank, 1991). Morse and Johnson (1991), in their illness-constellation model, also describe this disconnection process that a patient goes through which is triggered by the giving over power to a healthcare professional when seeking treatment for an illness. These researchers identified that often when people are being treated within the healthcare system they may have little or no input into the decision making process (Morse & Johnson, 1991). They describe this distancing process as a relinquishment of self, detachment from one's surroundings and the people around them, all as a result of the loss of power. Patient's describing this detachment indicate a surrealistic quality to
their experience. They feel as if they are watching someone else experience the illness and treatment rather than themselves (Morse & Johnson, 1991).

This phenomenon, which was relevant to every woman I interviewed, was evident in several ways. One example of such detachment was the frequent use of the second person "you" when the women described their experiences of depression, ECT and some life events. A second example, was the inability for most of the women to identify or name the depression and ECT, which instead was often described as "it" or "that". The experience of the "it" or "that" was an outside entity, somehow separate from themselves and one that invaded or attacked them. A third point highlights how only one of the women was able to make any links between any life circumstances and their emotional state. My aim here is not to refute the literature indicating a biochemical component to depression, however, the numerous instances of losses and difficulties these women experienced should not be dismissed. Interestingly, Schreiber (1996) in her grounded theory study of the experience of depression with women between the ages of 32 and 69 found that although some of the women believed that their depression was biochemically based, the majority of the women could and did tie their depression to circumstances within their lives. This is quite the opposite of the findings of my research. Schreiber (1996), goes on to describe the experiences of some women who identified that they had distanced themselves from their emotions years before their depression. Part of their healing process became acknowledging and dealing with those emotions (Schreiber, 1996). A fourth example is in how most of the women expressed difficulties in talking about their experiences and indicated to me that they had not been asked that much about their lives before and were unfamiliar with describing their experiences or emotions.
This concept of the disconnected self is a recognized phenomenon within the literature of illness experiences. Arthur Frank (1991) wrote of a similar phenomenon in his own experience with cancer. He expressed feeling detached from himself and his experiences and he identified this detachment as being related to a number of emotional and circumstantial triggers (Frank, 1991). First, he identified that he felt detached when he experienced medical personnel, friends and family depersonalizing his illness. A second trigger point was being treated as an entity under investigation rather than as a person. Finally, he felt disconnected due to a sense of a betrayal of himself by his body and the loss of control he felt over his own body and self. Once he identified this tendency to separate himself, he resisted the tendency to detach and expressed the necessity of remaining wholly present in his experience of illness and recovery.

Experiences are to be lived, not managed. The body is not to be managed, even by myself. My body is the means and medium of my life; I live not only in my body but also through it. No one should be asked to detach his mind from his body and then talk about this body as a thing, out there. No one should have to stay cool and professional while being told his or her body is breaking down, though medical patients always have to do just that (Frank, 1991, p. 10-11).

This same sense of betrayal and lack of control over their own self is certainly relevant to the experiences of these women.

Max Van Manen (1998) also writes about the experience of illness from a phenomenological perspective. He highlights one of the ten modalities by which the body and self experience illness. In the context of my own research, his discussion relating to what he terms the body concept of "The body of self as experienced in the modality of appreciation" is of interest (Van Manen, 1998, 11). This concept describes a view of self and illness as an intrinsic part of ourselves that is familiar. We notice our own illnesses or physical frailties such as disfiguring arthritis, but it is also a familiar part of us and it may go unacknowledged in our day to day
lives. Our concept of ourselves is disrupted when we are in the company of others who make us aware of these idiosyncrasies (Van Manen, 1998). This concept of self in relation to illness is not unlike the experiences described by the two women who did not identify themselves as being depressed. They had a disconnection of experience between their perceptions of themselves and what others were seeing in them. It was only from contact with family and medical professionals that there was a reflection of their illness and some understanding that there might be something wrong. It was the outsiders who came to define their illness.

Both Frank and Van Manen wrote of experiences with having a critical physical illness. An illness that truly was an invading force in their body, and one that had to actively be combated. The women I spoke with were struggling with their emotions, which are an intrinsic part of themselves. Arthur Frank's illness was one that could be isolated and potentially removed from his body. Emotions cannot be physically removed but it seems clear that experiences can become detached. Through this investigative process, I came to see how detached these women's experiences could be. It is my contention that what I have termed the disconnected self is a multi-faceted phenomenon that is evident across several dimensions of these women's experiences with depression and ECT.

The Power of the Dominant Medical Discourse

The influence the power of the healthcare professionals and medical model had on the discourse of these women was revealed throughout their experiences and was common to all of the participants. This insight is yet another dimension of power as well as disconnection. The use of medical jargon to described their depression; equating depression with purely physical illnesses; describing experiences of ECT in strictly procedural terms as it was described to them; and even accepting medically based myths about aging, are but a few examples. They have
come to see their depression as strictly a biochemical illness. "The feeling of unwellness has become an awareness of an entity that is a disease. I feel as if some thing is affecting me, and I say, 'I have come down with something' or 'I've got something" (Van Manen, 1998, p.9).

Because the illness in the case of these women is emotional however, it cannot be completely removed but as shown, it can become detached. This is the phenomenon I witnessed throughout the text of the interviews with these women. All six women in various ways spoke of their lives, their emotions and experience with ECT in very medicalized and depersonalized ways.

The ill person actively tries to make sense of what is happening in her body. She tries to maintain a relationship between what is happening to her body and what is going on in the rest of her life. When a person becomes a patient, physicians take over her body, and their understanding of the body separates it from the rest of her life (Frank, 1991, p.52).

This phenomenon is in keeping with a biomedical model and how depression is treated as a physical disorder. As previously noted in chapter 1, depression is viewed and treated almost entirely as a medical disease that someone becomes afflicted with. This belief system and treatment model entirely removes the experience of depression from life circumstances. In essence depression as an emotional response is no longer tied to situational causes at all. It is not surprising then that these women describe their experiences of depression as being akin to what could be interpreted as an alien invasion.

This could also be seen as a disengagement process. Through adherence to the dominant medical discourse, emotions and experience are viewed as almost physically tangible objects that can some how be seen outside of ourselves. As alluded to by the findings, the notion of emotions being separate from situational factors could be self-preserving to the women for two reasons. One, it keeps them from having to delve into difficult past and present life experiences.
which they did not like talking or thinking about. Two, it takes responsibility and treatment for the "illness" out of their hands and makes it potentially curable.

Arthur Frank (1991) speaks of the body as becoming the passive object of investigation when experiencing illness.

I, my body, became the passive object of this necessity, the investigation. I could imagine how native people felt when European explorers arrived on their shores, planted a flag, and claimed their land on behalf of a foreign monarch who would bring civilization to the savages. To get medicine's help, I had to cede the territory of my body to the investigation of doctors who were as yet anonymous. I had to be colonized (Frank, 1991, p. 51).

He goes on to explain how a disengagement process occurs between what is happening to a person's body due to illness and treatment and the rest of that person's life. This medicalization of emotion and experience then is yet another component of the disconnected self.

Reflecting again upon Van Manen's writings of the experience of illness the concept of "the body of self as self-observed" (Van Manen, 1998, p. 8) becomes very relevant to this discussion. Van Manen speaks of among other things how healthcare professionals are becoming more aware that they must treat the whole of a person and not separate the mind, body and soul since all are impacted by illness (Van Manen, 1998). However, he highlights that medical professionals are often forced into thinking in what he refers to as a "Cartesian manner" (Van Manen, 1998, p.9). In order for a doctor to make an abstraction from a person's often tenuous feelings of "unwellness" to a physical disorder, requires adopting an objectifying view of the patient's body (Van Manen, 1998). The language that derives from this objectified view of the body and minds of these older women could have a definite influence on how they view their illness and detach from their own experiences.
Implications for Change

The primary insight gained from this research project is that power is a defining element in all of these women's experiences and to the issue as a whole. Power and the lack of power not only regulated these women's agreement to treatment, it could have facilitated their becoming depressed (Brems, 1990). Power is also implicated in defining the model through which the healthcare system operates (Doyal, 1995; Longino, 1997). It is the power of the biomedical model and the structure of our healthcare system that regulate how we view depression and treat older women (Brems, 1990; Doyal, 1995). It could be said that it is a lack of power and choice that leaves these women disenfranchised and disconnected from their own experiences. The challenge then becomes reintegration.

Feminist Theory

The principles of feminist theory lend a foundation from which to understand and address the issue of power and its role in these women's experiences. Feminist and structural theory combine to assert that our social structures are organized in a way that discriminates against people based on their gender, class, race, sexual orientation, health and age (Mullaly, 1997). Feminist theory aims to change the organization of social structures so that oppressed members of society are treated equally (Flax, 1997). As noted previously, older women are among those most oppressed in our society. If a lack of power structurally in society is a potential factor in depression, then the recreation of power dynamics within the healthcare system may add to the problem being addressed.

From a feminist perspective, structural factors are implicated in not only what potentially creates depression in older women but how it is treated. In an economically managed care model, healthcare is focused on a quick, cost effective fix (Aronson, 1999). Particularly when
those being treated are often considered over users of the healthcare system (Beisecker, 1996) and economically unproductive members of society (Browne, 1995). Schreiber (1996) cites the research of Stiver and Miller (1988) which suggests that women's depression is the result of unacknowledged and mourned losses women experience throughout their lives. Such losses might include disappointments in marriage and family relationships, deaths, and abuse which if goes unidentified and not mourned, moves beyond sadness to the more debilitating state of depression. Within a medicalized model of depression, older women experiencing these very real losses and circumstances rarely have them acknowledged. Even within this study, several participants noted that they had rarely, if ever been asked so much about their lives. Current care that they received focused on the present only. The treatment then focused on a quicker solution that may have overlooked some very important factors. This practice can in turn reinforce the notion that older women as a group are not worth the time or the money it would take to change how they are treated within the healthcare system.

Empowerment Social Work Practice

Grounded in and complimenting the philosophical position of feminism, empowerment-oriented social work practice with older adults is a model which strives to value and foster connectedness and collective good (Browne, 1995). "Empowerment is a process through which individuals and groups become strong enough to participate within, share in the control of, and influence events and institutions affecting their lives" (Cox & Parsons, 1996, p.130). It also works on the basis of identifying and equalizing power differentials and building on client strengths (McInnis-Dittrich, 1997). In order to achieve this when working with an older adult population, it is a necessity to be cognizant of the multiple issues impacting the lives of these individuals, particularly older women. Issues such as multiple losses, chronic illness, social
isolation, limited mobility, diminishing cognitive abilities, loss of support systems, loss of social, family and societal roles and poverty are all some of the issues to keep in mind (Browne, 1995; Cox & Parsons, 1994). These issues all amount to a lack of power on the part of the older adult and seriously impact their ability to access resources and advocate for their own needs (Browne, 1995). In short, the issues and circumstances amount to oppression.

"Oppression is an inevitable result of 'power-over'. In order to end it, our challenge is to discover how we can restore the skills, methods and culture of 'power-with'" (Bishop, 1997, p.31). Oppression translates into powerlessness and I believe that as a social worker I must always be aware of the client's position and my own position of privilege and power in relation to others. The use of an empowerment model of practice, I believe, better addresses the full range of issues older adults face and does so within a context of recognizing people's right to care services while respecting their autonomy. The issues of power and oppression that this model of practice addresses are all relevant to the findings of this research.

"An empowerment-oriented approach encourages the active participation of clients in dealing with the personal as well as the interpersonal and political aspects of their problems" (Cox & Parsons, 1994, p. xv). Empowerment-oriented social work is a mutual process and has been identified as involving four essential elements: a sense of self, group validation of experiences, encouragement for critical thinking and development of action plans (Cox & Parsons, 1994). There are also a number of principles of practice inherent to empowerment-oriented social work and they are: a helping relationship based on trust and collaboration; fostering a sense of personal power within the helping relationship; incorporating mutual support networks and collective involvement; encouraging client strengths; teaching necessary skills; raising awareness of power dynamics and oppression; mobilizing resources and advocating for the
client; accepting the client definition of the issue; and involving the person in the change process (Cox & Parsons, 1994).

**Practical Applications**

The principles involved in empowerment-oriented social work practice can be applied both structurally and individually. In relation to the treatment of older women within the healthcare system, applying empowerment principles uniformly at a macro level requires advocacy and lobbying for a commitment to changing how our society has come to view health and what we value in our healthcare system.

Increasingly the health science professional is becoming aware that people require not only health care assistance, surgical treatment, or pharmaceutical treatment, but that the professional be much more involved in the way that people experience and live with their problems in a different, sometimes deeply personal and unique manner (Van Manen, 1998, p.1).

This requires structural change for example, in what models we use for service delivery. The currently used economically managed model is not conducive to the empowerment of users (Aronson, 1999). This is particularly the case for users who are structurally at a disadvantage, as older women often are. The focus on the financial feasibility of specific types of care practices, over-emphasis on the use of the biomedical model as well as the language used by the model objectify and depersonalize the healthcare process.

The impact of the dominant managed care discourse has been found to have significant repercussions particularly on older adults who are most impacted by this care model (Aronson, 1999). The language of scarcity, high demand, and being "case managed" have been found to lower older people's expectations of the healthcare system, but also leaves them disenfranchised (Aronson, 1999). In order to receive assistance, they must conform to very specific rules and restrictions, which often severely limits their autonomy.
Structural changes such as moving to another type of care model, a more wholistic one, take time, commitment, money and the socio-political desire to do so. As a result, this type of change does not readily occur. In the meantime, as social workers we must continue to advocate for these structural changes but also focus on what we can do individually to empower the older adults we work with.

On an individual practice level, there is a definite role for social work in facilitating the empowerment of older women, promoting the necessity for the incorporation of their voices in the healthcare system and clarifying the need for more choices. Empowerment-oriented social work practice could be utilized for this purpose. Fundamental to the practice of empowerment-oriented social work is advocacy, fostering strengths in the client, raising awareness of power dynamics and oppression, and developing mutual support networks (Cox & Parsons, 1994). These are four principles which could be utilized to facilitate working towards an alternative care model with these older adult women.

There is a clear need for advocacy in order to incorporate into the current treatment model time to just listen to these women. It is important to allow them the opportunity to speak of their lives and thereby present them with more alternatives. As noted in the findings, several of the women expressed surprise that I had asked them so much about their lives and as noted by one woman, she even thought I had asked her more than any other healthcare professional had about her life. This is problematic in that the women's depression is being treated in isolation from their experiences and environment. This can tend to limit the understanding of and treatment for their depression. Through the course of the interview process, at least half of the women found our interviews to be a very rewarding experience and they enjoyed speaking about their lives. It serves an important purpose to encourage these women to voice their
hardships as well as their triumphs. This practice is not necessarily for the purposes of diagnosing or for formal counselling, but it could be. The important aspect is to encourage more open expression. Gender role socialization played a powerful role in the lives of these women and part of the discourse they engendered was to not express themselves, not complain, just put up with circumstances and feelings. The socialization experience may not be able to be removed, but it could open an avenue to reinforcing that it is okay to express a full range of emotions, thoughts and ideas. The application of this practice could help foster strengths and facilitate change through encouraging these women to express themselves. Through social work practice, this could be achieved on an individual basis with older women.

Developing rapport and encouraging discussion with older women in this way could support two other purposes. One purpose would be to hopefully model with them the development of a professional relationship on a non-medical and more equitable basis. The second aim would be to support the object of raising awareness of power dynamics and oppression; however, it would not be my intent to entirely disrupt the worlds of these women. Another fundamental of this empowerment-oriented practice model is accepting the client's definition of the issue. If I were to accept the literal word of most of these women, there is no problem since they seemingly accept the current definition of the problem and model they are being treated under. This qualitative project was aimed at revealing the underlying experience of these women through analyzing not only the literal word, but specifically what and how language was used. Through this practice, a different picture of their experience emerged.

I would never claim to have expert knowledge of these women's depression, treatment or life circumstances, however, I believe everybody should have the right to all the information, be given choices and make fully informed decisions regarding their lives. As a social worker,
helping these women to acquire the knowledge of power and oppression is at least arming them with the information to make their own decisions rather than possibly allowing them to be made for them. Research into communication with elders supports creating a more inclusive treatment model between healthcare professional and clients, which would be facilitated by this process (Ryan et al., 1995). It was found that treatment plans that are developed in tandem with the elder and which are designed to match the unique situations of that individual, have a much higher rate of follow-through and success. In practice, this could take the form of openly discussing with the women their understanding of their experiences and circumstances. This is done while concurrently proposing different viewpoints, thus challenging their thoughts and perhaps planting a seed of alternative realities for what best fits best their own experiences.

Another method of raising awareness of issues of power and oppression, as well as promoting the value of collective experience, is facilitated through networking amongst older women, through the application of group work principles. "Mutual aid is a powerful dynamic for facilitating both self-esteem and problem resolution" (Cox & Parsons, 1994, p. 99). Group work is often preferred in empowerment practice over individual work since empowerment-oriented practice relies on consciousness-raising. Group work is ideally suited to achieving the purpose of consciousness raising. The goals of empowerment-oriented group work are: developing mutual support and self-help; increasing knowledge and skill in combating life challenges; fostering the ability to critically analyze one's life difficulties within their environmental context; and collective action (Cox & Parsons, 1996). In research, small group empowerment-oriented interventions have been found to enhance the quality of life for older women and support the development of meaningful and supportive interpersonal relationships (Cox & Parsons, 1996; McInnis-Dittrich, 1997).
Facilitating networking with other older women who share similar experiences, could be extremely beneficial for the women in this project. This type of support could be helpful to these women at all stages of their encounters with the healthcare system. Group work could be helpful prior to any onset of depression in order to collectively share experiences of losses and combat some internalized discourse, which may assist to normalize their situations and experiences. The organization of this mutual support network may in fact help inoculate the older woman from even becoming depressed (McInnis-Dittrich, 1997). While experiencing depression, peer group interaction could be a valuable tool in providing collective support, a venue for sharing struggles and a mode of counselling. The value of this form of counselling is that it is not done in isolation, since those who are depressed so often experience a sense of isolation. During the treatment process, once again group involvement could be instrumental in providing elder women with a network to share their experiences and gain information on treatment, arming them with the knowledge and choices to make their decisions.

Several of the women in this project actually identified the value of collective sharing, but were not involved in any such process. I asked several of the women if they knew of anyone else that had been depressed like themselves and/or had ECT. Some had known others that were depressed but rarely had talked about it with them and none had spoken to others like themselves who had ECT. This is despite several of the women who had gone on a regular basis for ECT as an outpatient and met up with other women in the waiting rooms. The women commented that they rarely spoke to others while awaiting their treatment. I understand that their reluctance to share their experiences with others may impart be due to the stigma of mental illness and the treatment; however, when asked whether they would like to speak to others if they had the opportunity, most said yes. I could see great value in connecting some of these
women together to share their experiences and work towards empowering themselves collectively. McInnis-Dittrich (1997), in her study describes the positive outcomes of the development of an empowerment focused, networking group with older women at high risk for mental health problems. Women involved in the group were reported to show fewer signs of mental health problems, they became more self-motivated, socially involved, and the members ultimately took over the running of the group. The women I interviewed did not necessarily express the interest in being empowered in the current process, however, they did clearly reflect a lack of choice in their statements. Part of empowerment social work practice is in raising awareness and educating collectively in order to provide choices for those involved in the process (Cox & Parsons, 1994). Further possibilities for the role of empowerment-oriented group work in working with older women who have experienced depression and ECT, is an area that should be investigated.

**Alternative Informed Consent Process**

As earlier noted, the process of informed consent is a critical issue pertaining to ECT and psychiatry in general, since individuals treated within the discipline are some of the most vulnerable (Breeding, 2000). The voluntary informed consent process as revealed by my research was not a very meaningful process for the women I interviewed. The women I interviewed indicated that they either did not remember signing a consent form, did but it was quite a while ago and/or it really did not matter to them, because they trusted the medical professionals involved.

Many would say that the current practice of informed consent works. The requisite steps are taken by giving the appropriate information and having the women sign and agree to it. There are two flaws in this logic. One is that the informed consent process is built on the basis of
biomedical ethics not just functional application (Abrams, 1997). There are too many structural factors and indications of powerlessness that are clearly at play in the lives of these women for the current practice to meet the requirements of autonomy. Two, is that if the informed consent process is to be useful, the women need to feel that there are other choices available to them. As earlier noted, the practice of autonomy in its application of the use of ECT, is being of free will to direct one's treatment (Abrams, 1999; Breeding, 2000). However, without choices in approach or treatment options there is not much freedom to direct one's own care. In direct application, fostering the empowerment of older women in the healthcare system could be one aim of social work practice. Another goal would be, as previously mentioned, to advocate structurally for the adoption of a more wholistic model of healthcare. Both these areas of practice and policy/program development and service delivery require further consideration and research.

Unfortunately, I have no precise answers to this issue only some cursory suggestions that are grounded in feminist and empowerment-oriented practice principles.

- First and foremost is the adoption of a more wholistic and user friendly healthcare model which incorporates alternative views of depression and treatment in order to create more choices and empower older women in the process.

Specifically, in terms of the process of informed consent, and working from an assumption of alternative views and choices available, some suggestions for implementing change are:

- There is the possibility of requiring an ongoing consent process that updates the information with each client before each course of treatment. This process could be completed, at least after the initial instance of severe depression, while the person is not depressed so that emotional state does not interfere with the decision making process.
• Memory difficulties or heightened emotional state at the time of signing may be an issue in
not being able to recall signing the consent. In this case it may be feasible to provide a
detailed copy of the form or document noting the rights involved regarding the treatment
process. This would enable individuals to refer back to the document if necessary. This
creates a higher likelihood that the individual will be familiar with the process and
understand what procedure and rights are involved.

• The informed consent process could be completed by a designated body or healthcare
advocate which is separate and distinct from the medical environment through which the
individual is being treated. Healthcare advocates could be assigned to be involved through
the whole treatment process. Their role would be to explain the process in advance, witness
their acceptance, monitor the treatment process and re-educate the person throughout the
process as to what is involved. Some people would claim that this is the role of family
members. Family members are not impartial and are often, quite understandably,
emotionally involved in the situation. They are also not necessarily any more aware of what
to expect than are the treatment recipients. The advocate should be a neutral party and very
well versed in the process. The value of this suggestion is that it at least starts to approach
power differential issues inherent between the healthcare professionals and older women.

Unfortunately, only the last suggestion even begins to adequately address the structural
issues involved which put these women's ability to consent into question. Given the importance
of the informed consent process in the practice of ECT and psychiatry in general, I believe this
is an area that requires further consideration and exploration. My intent is not to be paternalistic
about the necessity of advocacy for older women within this process. My conviction is based
upon the belief that the current practice cannot accommodate an understanding of the many
dimensions of power and lack of choice that may prevent these older women from truly making an informed decision as to their treatment.

There is no doubt that medical care for the older adult should be a right and a necessity, but all care of older adults need not be so highly medicalized and inherently power laden. In healthcare, social workers can play an important role by helping to insure that older women's experiences are heard and that their needs are being acknowledged and not just within the context of a medical model. We need to ensure that older women's dignity, respect and wishes are being addressed and that they are given a true voice and choices in the decision making process of their care. What is necessary is a more encompassing and wholistic view of health and a system that is inclusive of all people and their experiences.
CONCLUSION

The dominant biomedical model has made a significant impact on how we view depression and aging within the context of a disease model. A feminist critique of this model is that it is a restrictive perspective, which overlooks the structural, circumstantial, and gender socialization factors that may contribute to older women's depression. An alternative feminist model, while not necessarily refuting a biochemical component, advocates for incorporating a more wholistic view of women's emotional and physical health. It becomes necessary then to promote the inclusion of women's voices in the healthcare policy making, program development and service delivery process in order to facilitate an alternative view and empower these women within the process. Specifically, this research project explored how older women have experienced depression and receiving electroconvulsive therapy (ECT) as a treatment.

The methodology utilized by this project was a qualitative, phenomenological method of inquiry, which was informed by the theoretical perspectives of hermeneutics, feminist theory and post-modernism. The data analysis, which was comprised of individual case analysis, discourse analysis and thematic categorization, revealed that these women's experiences could be described as a four-part metaphoric journey. The four stages of their experiences were: the invasion/becoming depressed, finding allies/conditions of getting help, the rescue/the treatment, and the journey home/hope for recovery. The dominant theme of power and its various dimensions was evident throughout the four-part journey of these six women's experiences with depression and ECT. The power held by healthcare professionals was predominant in the discussion as well as its implications on alternative choices and the informed consent process. Stemming from this power was the demonstration of the disconnected self, and the role of the dominant medical discourse in the lives of these women. Feminist theory and empowerment-
oriented social work practice can be essential tools in breaking down the barriers and
dichotomies of power, inequities, and lack of choice that exists and perpetuate the
disempowered role that older women have in our society and specifically within the healthcare
system. Individual and group empowerment-oriented social work practice could be utilized in
combating these inequities, altering the informed consent process and facilitating older women
in having a voice in the healthcare process.

In the findings chapter, I describe these women's experiences as a four part journey, albeit a
journey that consisted of an invasion, but the final section is titled their journey home. For their
hopes of recovery and their futures, most of the women expressed the sincere desire to live
freely and peacefully. My aim in completing this specific project was a desire not to lay blame
on the medical professionals specifically, but to raise questions about the societal structures that
perpetuate the lack of power and choices of older women or any member of society. I wish to
honour the experiences of these brave women and I believe their insights have a role in our
healthcare system. My wish for these women is that their journey home be a peaceful,
reconnection with themselves.

Sometimes in your life you will go on a journey.
It will be the longest journey you have ever taken.
   It is the journey to find yourself
   -Katherine Sharp
BIBLIOGRAPHY


APPENDIX A - ETHICS APPROVAL CERTIFICATE
APPENDIX B - VRHB APPROVAL LETTER
APPENDIX C - AGENCY APPROVAL LETTER (GPOT)
APPENDIX E - PARTICIPANT CONSENT FORM
I hereby consent to participate in the study described above. I have received a copy of this consent form.

______________________________  ________________________________
Name (please print)                         Signature

______________________________
Date

Please Circle One:

I do / do not give permission for the principal investigator to use the information I am providing as part of a larger study focused on the same issue.
INTERVIEW GUIDE

Research Question

How have older women experienced depression and receiving electroconvulsive therapy (ECT) as a treatment?

Sub-questions

1. What were these women's subjective feelings and factors surrounding their depression?
2. How were these women emotionally, psychologically and/or spiritually impacted by ECT?
3. Do the women feel that they were fully informed and prepared for what to expect of the treatment they underwent?
4. Do these women feel that the treatment mode was necessary and justified?
5. Do they feel that they were helped by the treatment?
6. Does their experience of ECT make a difference to how effective they perceived the treatment to be?
7. How can inclusion of experience impact healthcare practices/policy and use of ECT?

Interview Questions

1. Describe to me what your life was like prior to your depression?

   Prompts:
   • Describe any situations or circumstances that occurred in your life before or during your time of being depressed?

2. How did you make sense of your depression?

   Prompts:
   • Are there any circumstances or situations that you could identify as related to your depression?

3. How was ECT described to you by doctors or other medical personnel?

   Prompts:
   • How did they prepare you for the treatment?
   • Were you told about what to expect during and after the treatment?
4. Tell me what it was like for you to receive ECT for the first time?

Prompts:
- Why did you have to have ECT?
- How did you feel and think before, during and after the process?
- How do you think the treatment impacted your life?

5. How did you feel after receiving the ECT?

Prompts:
- Do you feel the treatment was effective?
- Did you find the relief from the depression you had hoped for?

6. Given your experiences with ECT, would you recommend it as a treatment to someone else? Why or why not?

Prompts:
- Anything negative about the experience?
- Was the experience worth the outcome?
- Do you feel that other people would perceive the treatment as you have?