

ACCEPTED **Giving Voice to Women's Experience of Depression**

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ABSTRACT

The purpose of this research was to gain understanding of women's experience of depression using a phenomenological-hermeneutic approach. Data was obtained from psychotherapy sessions with seven women who were diagnosed as clinically depressed. The sessions were audiotaped and then transcribed. The transcripts were analyzed using Van Manen's approach. Several interesting themes emerged from these transcripts: (a) living environment, (b) experience of time, (c) intimate relationships, (d) the body out of balance, (e) language, (f) medication, (g) symptoms, (h) distortions of thought, (i) telling the story, (j) from victim to survivor, and (k) coping strategies.

The results of this research indicate that women have a knowledge and understanding of depression that is a valuable resource for clinicians and researchers studying depression.

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I am indebted to the seven women who participated in this study. Their courage and integrity were inspirational. Finally, I wish to thank my mother for her strength and wisdom.

DEDICATION

This dissertation is dedicated to my husband, Mark, for his love and patience, and for his assistance in editing the manuscript, and to my son, Mark, who taught me as I raised him.

INTRODUCTION

The Question

Depression is a disorder of mood, so mysteriously painful and elusive in the way it becomes known to the self--to the mediating intellect--as to verge close to being beyond description. (Styron, 1990, p.7)

The purpose of this research is to address the following question: what is the meaning of depression to the women who experience it? The research method to be employed is the phenomenological-hermeneutic approach. A detailed discussion of this approach follows in the chapter on method; however, a brief definition is here provided for present purposes.

The term phenomenology is defined as: "The study of all possible appearances in human experience, during which considerations of objective reality and of purely subjective response are temporarily left out of account" (Morris, 1970). Phenomenology comes from the Greek word *phainein*, which means to show.

Hermeneutics means interpretation and comes from the Greek root *hermeneuo*, to interpret. Hermeneutics is

essential in this study as a tool to take the phenomenological data from women who are depressed and interpret it meaningfully. According to Osborne (1990, p.89), "Clinical diagnoses and the interpretations of phenomenological research data demand a hermeneutically oriented approach which requires not only a perceptive intelligence but a kind of pathic knowing which enables the counsellor or researcher to read between the lines to pursue clinical hunches."

In phenomenological research, the researcher begins with his or her own experience: "It is important that women start from their own experience, especially when it may not 'make sense'" (J. B. Miller, 1986, p.142). My own experience of depression is an essential tool in the study of the lived experience of depression, and enables me to empathize with other women's experience of depression. I have spent several years in study, thought, and clinical work on the subject of depression. I first became interested in this subject when my maternal grandmother became depressed several years ago. I saw her change from a woman who was vivacious, generous and loving to one who was withdrawn and preoccupied. It was painful for me to visit her during her depressed period of approximately two years. My mother also experienced depression.

Seeing my grandmother in such pain was difficult; it was unbearable to see my mother in this state. My desire to help my mother led me to a search for a deeper understanding of what it means to be depressed. I researched the subject by reading the literature on depression, discussing depression with professionals in the mental health field, speaking to those people who were experiencing depression, and working in a hospital in Ottawa conducting therapy groups for people who were depressed. The majority of my patients experienced symptoms of depression.

I asked my mother if she would assist in my research by describing her experience of depression. She was happy to contribute to my research, and wrote about her experience and beliefs about her depression in a letter, from which I have quoted as follows:

The first time I was deeply depressed was when T. [the youngest of her eight children] left home. It hit me all at once. I was out working in the garden and the school bus came by; I waited for T. to get off and suddenly realized that all of my family were gone and nothing would be the same again. I felt helpless, was not able to stay alone and would wait at the door for Dad to come home from work. There

was nothing to look forward to, just emptiness
(personal communication, June 8, 1990).

When I began writing my dissertation I was pleasantly surprised by the reaction of friends and colleagues upon hearing that I had decided to write about women's experience of depression. They were very interested in this topic because of their own, or a loved one's, experience with depression. The following quotations will serve to provide the reader with some examples of personal descriptions of depression:

1. *"It is as if you were lonely to the point you were not able to carry on, there was nothing to look forward to--just emptiness."*
2. *"Unable to do anything except sit and stare into space."*
3. *"Depression is like an illness, a physical illness, where my body aches, and I feel as if there is such a heavy weight on top of me that I cannot move."*
4. *"At its lightest, depression is a pervasive, always present tinge of sadness, which I feel just behind my eyes, a sensation of wanting to cry, always."*

General Characteristics of Depression

The central characteristic of depression is the feeling of intense and pervasive unhappiness. The feeling of anxiety also often accompanies depression. Other feelings include helplessness, hopelessness, worthlessness, and a desire to commit suicide. Some report an experience of fatigue or lethargy, while others experience agitated physical movement. The depressed woman interprets what goes on in her life according to her interests and intents. When depressed, a woman often dwells on exaggerated memories of losses or failures, or focuses exclusively on the negative aspects of life. Her negative thoughts can erode her self-esteem and result in an unrealistic sense of worthlessness. Her behaviour is usually egocentric and self-destructive. As a result of feeling depressed, she tends to withdraw from others and become introspective. She maintains less eye contact than other women, speaks less, and when she does talk it is more monotonously and softly. She takes longer to respond to others. She communicates helplessness, so that no matter what other people do for her, it seems not enough. Her behaviour usually engenders a negative response in others and causes the depressed woman to feel isolated.

As a result, her downward spiral into depression accelerates.

Research Method

The approach that is best suited to my research is the phenomenological-hermeneutic one, because it is a tool for the study of personal experience, and I am interested in researching women's experience of depression. I decided to use this approach after reading Woman to Mother: A Transformation (Bergum, 1989). I found her writings on women's experience of giving birth exciting and interesting. Bergum's dissertation evoked long forgotten memories of when I gave birth to my son. I identified with these women and was touched by their pain and joy. The phenomenological-hermeneutic approach Bergum used enabled me to intimately understand the women's experience of childbirth. I decided to use the same approach for my research in order that women's experience of depression would come to life as surely as had the women's experience of childbirth in Bergum's research. Several other writers have used this approach to elucidate a variety of personal meanings. For instance, Ferguson (1990) poignantly described her experience of cancer; Maeda-Fujita (1990) wrote about the lives of mentally

handicapped children; Olson (1986) described her experience of illness as a patient on dialysis; Smith (1984) explored the meaning of children to the lives of adults who care for them.

Participants

The art and discipline of being a psychotherapist involves developing the grateful receptivity to hear, accept, and bring into illumination what kind of gift each patient brings to the consultation room (Moss, 1989, p.203).

I decided to investigate women's experience of depression within a group setting. My previous encounters with groups, including working with therapeutic groups in a psychiatric hospital in Ottawa, and teaching a course in group counselling, convinced me that group therapy is valuable for women suffering from depression. The group setting is also ideal for research purposes, providing a rich lore of phenomenological data. Groups provide a unique opportunity for members to assess themselves, to validate their experiences and perceptions, to attempt personal changes, to express feelings, and to receive feedback and support. I. D. Yalom (1985) claims that

"many patients enter therapy with the disquieting thought that they are unique in their wretchedness, that they alone have certain frightening or unacceptable problems, thoughts, impulses, and fantasies" (p.7). Yalom calls the experience of connectedness discovered by participants in group therapy "universality". I have also ascertained that group therapy is particularly successful because it allows people to become intimately connected with others who have similar problems. In the therapy group, members often experience a deep sense of relief upon hearing other group members disclose concerns similar to their own.

Group therapy has its disadvantages as well. Examples are: potential breaches of confidentiality among members, the possibility that a shy person may be overlooked, and the inhibition that some members may feel regarding sensitive personal issues revealed in a group setting. Such issues would be better dealt with in individual therapy. In order to address the issue of privacy in the research group, I offered to provide each of the women with a one-hour individual session. Five of the women took advantage of this offer. These sessions were confidential and are not included in this research.

I approached the Victoria Mental Health Centre for assistance with my research. Arrangements were made at this facility for me to lead a group composed of depressed

women. Nine women were referred to my group, each of them diagnosed as clinically depressed by her psychiatrist. One of the women referred declined to participate in the group, and another was deemed inappropriate for the study because she was suffering from psychotic delusions. I met with the remaining seven women once a week for two hours, for a period of six months.

I gathered data during the sessions through audiotape, visual observation, and notetaking. The conversations were transcribed and analyzed for themes that emerged during group sessions. In accordance with phenomenological enquiry, I endeavored to suspend my expectations and assumptions. In order to understand the participants' experience of depression I attempted to listen to their words with an open mind, unobstructed by prior assumptions. My intent was to be attentive and empathic, in the spirit of the following quotation from McElroy (1990, p.209): "Being authentic (or real) in relationship with another is at the heart of collaborative action research, and is at heart a matter of ethics."

Psychotherapist as Researcher

I take an existential approach to psychotherapy, because I believe that the therapist must enter the

client's subjective world without presuppositions that would get in the way of the experiential understanding. I believe that the purpose of psychotherapy is not to cure clients, but to teach them to listen to their inner voices, to live authentic lives (J. B. Miller, 1986), and to take responsibility for their actions. As a psychotherapist, I must be in touch with my own phenomenological world in order to enter into the subjective world of my clients. Tenets of existential psychotherapy include: a) the emphasis on the individual's freedom and responsibility for his or her own existence, b) the process of becoming an individual, c) the challenge to authenticity in existence, and d) the positive role of depression as a medium for change and growth. In an existential orientation to the treatment of depression, patients should have the freedom and responsibility to experience the productive aspects of depression and be supported to find meaning and purpose in their lives.

Giving Voice to Women's Experience

We must find a different voice, a new place currently unrecognized, from which to speak about the nature of our lives together. (Shotter & Logan, 1988, p.70)

The concept of voice is an important one in this study. In my work as a psychotherapist I have discovered that women who come for psychological help rarely speak with their inner voices and rarely believe their own words and perceptions. Perhaps it is because these women are rarely listened to or believed. I agree with Belenky, Clinchy, Goldberger, and Tarule (1986, p.18), who wrote "that a sense of voice, mind and self [are] inextricably interwoven." In other words, if women are not able to speak with their own voices, perhaps they are not able to experience their selves in the way that self is generally defined in modern psychology (Kohut, 1980). I have attempted to amplify and explicate the inner voices of each of the seven women in this study to seek a new understanding of the nature and meaning of depression.

Researchers have only recently begun to describe how women give voice to their experience of the female world (Belenky et al., 1986; Gilligan, 1982; J. B. Miller, 1986; Rose, 1988; Scarf, 1988). I believe that the next step is to include the female voice and perspective in psychological and medical research on depression. From reading this literature on depression it is clear to me that the voice and experience of women have been excluded. The current study is an attempt to remedy the situation.

I believe that we come to know ourselves and others better through our stories and by giving voice to our experience through writing, through speaking, or through the arts. Wenz and McWhirter (1990, p.41), in a review of the literature on the use of personal and creative writing as an adjunct to group therapy, claim that "discovering the authentic 'voice' through creative writing exercises is an exciting process for clients. In group work that excitement is multiplied." Many of us have gained deeper insight into the life of a young Jewish girl hiding from Nazi persecution, from the diary of Anne Frank (A. Frank, 1952). Similarly, the joys and struggles of what it means to be a writer can be vicariously experienced from the diary of Virginia Woolf (Woolf, 1978).

It is not coincidental that my interest in reading about women having their own voice began when I discovered my own. I had been suffering from depression and my therapist advised me to leave my unhappy marriage, return to university, and to live my life more authentically. His advice was exactly what I needed. I followed it and I have never regretted my decision. While the advice originated with my therapist, it resonated with my own inner voice.

I have counselled clients to listen to their inner voices in order to empower themselves. I believe that

many women become depressed because their voices are not heard by their families, friends, and professionals. As a therapist I must be willing to sit with my client's pain and hear her story. We all have sorrowful and painful experiences and we all need the opportunity to experience them. As my clients find their voices, feel listened to and understood, they develop self-worth and move towards authenticity.

Recently I received a phone call at 5:00 A.M. from a client of mine. She said, "I just needed to hear your voice." She promised to meet me later in the day and I discovered in our session that she had attempted suicide. She had tried to hang herself, and yet stopped when she heard a little voice inside say: "call Mary Lou."

Duerk (1990) described the nature of a woman's voice in a way that will help to define voice as it will be used throughout the current study:

Most helpful of all for a woman to remember as she seeks her own voice, is that it will emerge only when she speaks from her own true nature and experience, only when she expresses what she cares most dearly about and is her own unique and individual truth.

(p.76)

REVIEW OF LITERATURE ON WOMEN AND DEPRESSION

The purpose of this chapter is to review the literature on women and depression. I will begin by defining the term depression and recount its history. Next, I will describe the aetiology of depression and review the findings of the major theorists in the field. Finally, I will outline prominent methods of treatment and therapy.

Definition and Diagnostic Criteria

The standard medical reference (Dorland, 1988) defines depression as:

A mental state of depressed mood characterized by feelings of sadness, despair, and discouragement. Depression ranges from normal feelings of "the blues" through dysthymia to major depression. It in many ways resembles the grief and mourning that follow bereavement; there are often feelings of low self-esteem, guilt, and self-reproach, withdrawal from interpersonal contact, and somatic symptoms such as eating and sleep disturbances.

The clinical syndrome of depression has been recognized for over two thousand years and yet no

satisfactory explanation of its puzzling and paradoxical features has been discovered. Known as the "common cold" of psychiatry, the syndrome of depression continues to inspire debate regarding its classification, its aetiology, and its characteristics.

The meaning of the term depression differs according to the context: the meaning in clinical work differs from that in research and that in common usage. The professional literature refers to the term as a nosological entity, as a symptom, and as a syndrome. The discussion here will be confined to the syndrome, which is defined as an event with affective, cognitive, motivational, behavioural, and physiological dimensions. The symptom will be regarded as a component of the syndrome.

Definition

The Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R) contains the most widely used definition of the syndrome of depression (American Psychiatric Association [APA], 1987). The component symptoms include: (a) depressed mood, (b) markedly diminished interest or pleasure in usual activities, (c) significant weight gain or weight loss when not dieting,

decrease or increase in appetite, (d) insomnia or hypersomnia, (e) psychomotor agitation or retardation, (f) fatigue or loss of energy, (g) feelings of worthlessness and excessive or inappropriate guilt, (h) diminished ability to think, concentrate, or make decisions, and (i) recurrent suicidal ideation, suicide attempts, or specific plans for committing suicide. A DSM-III-R diagnosis of major depressive episode is made if the patient reports or displays at least five of the nine symptoms. One of the five symptoms must be either (a) depressed mood or (b) markedly diminished interest or pleasure in usual activities. The depressive symptoms must have been present most of the time over a two-week period. It must be determined that the symptoms are not due to organic factors, normal bereavement or a primary psychotic disorder.

Phenomenological Characteristics

In order to provide a phenomenological perspective on the definition of depression, I have included the following clinical case example of the thoughts of a woman (RN) during a depressed episode. RN kept a journal of her experience of depression as part of her therapy. A thirty-six year old professional woman, RN had suffered

from depression since she was seventeen years old. She was hospitalized for a suicide attempt at age twenty-three, and had taken various anti-depressants since then. Married for twelve years, RN described her husband as kind and supportive. She frequently stated that "He's all I really live for." During a depressive episode, she described her experience as follows:

*Feel more discouraged, pessimistic, hopeless.
Scream! Drown in a whirlpool of water. It's sucking me under. Losing confidence. Down on myself. Feel like crying, and going to sleep for a long, long time. Then when I wake up, I'm a new person. It's agonizing; my heart is so heavy. It's sinking, sinking, down a black well filled with tar. It's so deep I can't get out. The rescuers can't reach me. I suffocate and die in the tar-filled well.
Wonderful death. Peace at last. Oh no, I've gone to hell. Fire! The burning tar is so hot! Please forgive me. Scream! Agony! I hate my soul/character. I'm so ashamed. Slit my throat. Bang my head against the wall. I need air. Fresh air.*

Associated Symptoms and Effects

There is a voluminous body of research showing the correlation of depression with physiological processes. A. T. Carr (1984) noted that depression plays a significant aetiological role in "essential hypertension, headaches, duodenal ulcers, sexual dysfunction, insomnia, obesity, alcoholism etc..." (p. 191). Most people understand the affective experience of being depressed but few people realize that depression can be masked by addictions, eating disorders, somatic complaints, and interpersonal conflicts.

The effects of depression are so encompassing and invasive that they frequently dominate the lives of the patient and family. Individuals suffering from depression experience definite changes in behaviour, attitudes, motivation and cognition. Carr (1984) stated that:

The depressed person usually affects those around him by virtue of inactivity and negativism, rather than by deviant or disruptive activity. The negative views of the past, present and future, the feelings of hopelessness and worthlessness, the lack of interest and motivation and the slowing of thought and behaviour, which are central to many depressive

reactions, mean that the person can no longer fulfill previously active roles. (p. 199)

The diagnosis of depression can occur at any point in the life cycle. It is manifested in the infant as anaclitic depression, a reaction to early maternal separation (Bowlby, 1969). In childhood and adolescence, depression appears as dysfunctional behaviour and suicide. Depression in its many forms is prevalent throughout the adult years and even with the aged.

The problem of depression is of enormous proportions in terms of human distress and the consequent demand upon health and social services. Klerman, cited in M. M. Weissman and E. S. Paykel (1974) claimed that:

A new age of melancholy may be upon us as Western Society confronts the gap between the widespread hopes for economic and social progress promised by the marvels of technology and the realities of the earth's limited resources, the dangers of uncontrolled population growth, and the failures of political movements to produce social justice. Depressions seem to arise not when things are at their worst but when there is a discrepancy between one's aspirations and the likelihood that reality will fulfill these wishes and hopes, whether for

oneself, one's family, or the larger social group with which one identifies. (p. x)

Cognitive and Emotional Aspects

Mood changes are hallmarks of the human experience. Many of us have felt depressed at some point or another in our lives and it is as normal as to feel frightened, angry, or happy when circumstances provoke these reactions. In depression of clinical proportions the woman is not simply "down" or "blue", but holds so firmly to negative views of herself, her past and her future, that these thoughts assume a delusional quality (A. T. Beck, 1967).

Measurement Instruments

Various scales, such as the Beck Depression Inventory (BDI) and the Hamilton Rating Scale for Depression are used to diagnose and assess the severity of depression. The Beck Depression Inventory A. T. Beck (1978) is one of the most widely used patient self-report instruments for depression screening. It provides a sensitive index of the severity of depression and has yielded an acceptable reliability and validity coefficient. It is easily scored

by summing the ratings from 21 items. Each item is rated on a four point scale (0 to 3) of intensity. Scores may range from 0 to 63, with higher scores indicating greater severity of depression. A score of 10 (sensitivity of .92) has been suggested as the optimal screening cut-off score for depression. The following are generally agreed upon guidelines for interpreting levels of depression from the BDI scores: 0 to 9 signifies no depression; 10 to 15 indicates mild depression; 16 to 19 denotes mild to moderate depression; 20 to 29 represents moderate to severe depression, and a score of 30 or above signifies severe depression.

Classification

According to Brown and Harris (1978), "Clinical work as well as research is impossible without a means of reducing the variety of psychiatric phenomena to a provisional order. This can only be done by classification" (p.19). Following are the depression classification issues and diagnostic signs and symptoms as compiled by Wetzel (1984).

Endogenous-exogenous schema.

Endogenous:
depression caused by internal factors.

Exogenous:
depression caused by external factors.

Reactive-autonomous schema.

Reactive:
characterized by positive response to treatment and modification of the environment.

Autonomous:
characterized by lack of response to intervention.

Psychotic-neurotic schema.

Neurotic:
depressive symptoms are from mild to severe intensity without loss of contact with reality.

Psychotic:
depressive symptoms are of extremely severe intensity with loss of reality contact.

Primary-secondary affective disorder.

Primary Affective Disorder:
no previous history of psychiatric disorder other than depression or mania.

Secondary Affective Disorder:
Pre-existing history of major mental or physical illness other than depression or mania.

Unipolar-bipolar types.

Unipolar Type:
recurring depression.

Bipolar Type:
recurring mania with oscillation between severe manic (euphoric) or depression (dysphoric) episodes.

Diagnostic Signs and Symptoms

Affective feeling state.

1. Dysphoric mood: sad, blue, dejected
2. Fearfulness
3. Anxiety, nervousness, worry, apprehension
4. Inadequacy
5. Anger, resentment, rage
6. Guilt
7. Confusion
8. Fatigue
9. Hopelessness
10. Irritability

Cognitive processes.

1. Negative view of the world, self, and future
2. Irrational beliefs
3. Recurrent thoughts of hopelessness
4. Recurrent thoughts of death or suicide
5. Self-reproach
6. Low self-esteem
7. Denial
8. Indecisiveness
9. Slow thinking
10. Little interest in activities, people, pleasure
11. Confused thought
12. Poor concentration
13. Agitation

Behavioural activity.

1. Dependence
2. Submissiveness
3. Poor communication skills
4. Excessive crying
5. Withdrawal
6. Inactivity
7. Careless appearance
8. Retarded speech and motor response
9. Agitated motor response: pacing, handwringing

Physical functioning.

1. Low energy

2. Weakness
3. Fatigue
4. Sleep disturbance: insomnia or hypersomnia
5. Weight loss or gain
6. Appetite disturbance
7. Indigestion
8. Constipation
9. Diarrhea
10. Nausea
11. Muscle aches and headaches
12. Tension
13. Agitated or slowed psychomotor reflexes
14. Sex-drive disturbance

Epidemiology of Depression in Women

The evidence is clear that women suffer from depression considerably more than men. M. Weissman and G. Klerman (1977) undertook an epidemiological investigation and discovered that a diagnosis of depression is made between two and three times as often for women as for men. According to Charney and Weissman (1988), "In almost all studies conducted in Western industrialized nations, women had shown rates approximately twice that of men for depressive symptoms as well as for nonbipolar depression. In contrast, the rates for bipolar disorder did not differ" (p.51). Lentz (1990, p.251) claimed that "depression is present at any given time in 2% to 3% of the male and 4% to 9% of the female population, with a lifetime prevalence of 10% in men and up to 25% in women." In the Lundby cohort study in Sweden, Rorsman et al.

(1990) evaluated the mental status of 2612 individuals for mental disorders in 1957 and 1972. They discovered that "up until 70 years of age, the cumulative probability of suffering a first episode of depression was 27% in men and 45% in women" (p.336). Russo (1985, p.10) stated that:

Biological, endocrinologic, and genetic factors, as presently understood, are not sufficient to explain gender differences in depression. There are, however, a wide variety of stresses that directly or indirectly have more impact on women and contribute to higher risk for this disorder: physical and sexual abuse, sexual harassment, sex discrimination, childbearing and childrearing, unwanted pregnancy, divorce, poverty, and powerlessness.

Theoretical explanations regarding the prevalence of depression in women include genetic and endocrinological factors, depressogenic variables in women's socialization process, the learned helplessness model, the cognitive model of depression, the effects of marital and occupational roles, and social discrimination against women. I believe that the latter factors are important. The following also need including: the lack of direct achievement, high interpersonal responsibility, low power and status, economic dependency, and traditional sex-role attitudes all predispose women in our society towards

depression. The following studies analyzed the differences between male and female socialization and suggested that women are predisposed to be depressed as a result of this socialization.

Studies by Chodorow (1978) indicate that the task of individuation means danger to women, while intimacy is viewed as safe and desirable. She notes that girls see themselves as having less individuality than boys. They have more permeable ego boundaries because they view themselves as extensions of their mothers. Men see individuation as an easy task, while intimacy is assessed as dangerous. Both are affected by each other's experience. Females are prone to depression because they have not developed autonomy and environmental mastery. Because they are relational, as described above, they will be frustrated by their emotional involvement with males, who tend to be nonrelational. In her analysis of contemporary child rearing practices, Chodorow noted the importance of emotional relational bonding in young women, in contrast with the abstract, work-oriented ties to the social world valued in the rearing of male children. According to Wetzel (1984), "Research indicates that women have been socialized to emotional dependence and that cultural realities insure their physical and financial dependence" (p.102).

Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel (1970) tested the hypothesis that the standards for evaluating mental health differ according to sex. Male and female practicing clinicians were given a set of 122 bipolar adjectives, each of which describes a behaviour trait or characteristic such as: (a) very aggressive--not at all aggressive, and (b) doesn't hide emotions--always hides emotions. The clinicians were divided into three groups. The first group was asked to indicate, for each item, to which pole a mature, healthy, socially competent man would be closer. The second group was asked to rate a mature, healthy, socially competent female. The third group rated a mature, healthy, socially competent adult, sex unspecified. The results revealed that the clinicians strongly agreed on the characteristics of healthy men, healthy women, and healthy adults, sex unspecified. But while the concepts of the healthy, mature man and the adult were not different from each other, the clinicians were significantly less likely to attribute to healthy women the same traits they saw in the healthy adult. Women were seen as more submissive, less independent, less adventurous, more easily influenced, less aggressive, less competitive, more excitable in minor crises, more emotional, more conceited, and less objective.

The latter finding suggests that the perception of the healthy personality is based on a masculine model, and that women who conform to the female model are then in the position of being viewed as normal and deviant at the same time. According to the authors, the double standard of mental health clearly reflects role typing and sexual stereotypes. It holds, first, that the criteria for judging certain kinds of behaviours as normal differ for males and females; second, that the traits which make up the male criteria are the norm for the healthy adult and are more highly valued in this society; and third, that females who conform to the female criteria are not healthy, by definition. The woman is put in a precarious double bind: if she behaves in a feminine manner, she embodies a collection of traits which are negatively valued. Broverman et al. (1970) suggest that if a woman behaves in a masculine way, she violates the behavioural norms for her sex and becomes subject to all the sanctions imposed upon deviants.

Verbrugge (1986) explored the role burdens which are experienced by men and women. Job schedules, feelings about roles, time constraints and pressures, and family responsibility, appear to be linked to health. She discovered that "women are more at risk of poor health because, more often than men, they tend to have few roles

(especially nonemployment), more dissatisfaction with their main role and life, low time constraints, low income responsibility, and irregular job schedules" (p.47). Waldron and Herold (1986) reported similar findings in an analysis of longitudinal and cross-sectional data. They discovered that women who were in the labour force were healthier than women who were out of the labour force. Furthermore, women whose job status was compatible with their attitudes towards employment were healthier than women for whom there was a discrepancy between labour force status and attitudes. M. M. Weissman and E. S. Paykel (1974) stated that "one of the protective functions of work outside the home is that it allowed the woman to escape the otherwise omnipresent demands of the family" (p. 75).

History and Aetiology

Descriptions of affective disorder began with Hippocrates; the term melancholia is attributed to him. The 19th century French physician Falret described an episodic variety of depression with remissions and attacks of increasing duration. The illness occurred more frequently among women than men, was sometimes associated

with precipitating events, and sometimes alternated with depression and mania.

Psychodynamic influences.

Abraham was the first of the psychoanalytic writers to develop a theory of depression (Kaplan & Sadock, 1985). He described the depression-prone person as dependent, sensitive to loss of love, and having basic defects in self-esteem. Freud developed his concepts of depression in 1917 from the theories of Abraham; he further postulated that vulnerability to depression was related to an early loss. He discovered that a recent loss, whether real or imagined, caused a recapitulation of the earlier loss and consequent feelings of resentment towards the loved person. Unable to express the resentment directly, the patient instead turns it inward towards herself. Rado agreed with Freud and Abraham on the concept of unexpressed hostility. Rado also emphasized the importance of the dependency found in people who are depressed. Bibring focussed on the loss of self-esteem.

M. M. Weissman and E. S. Paykel (1974) disputed the theories of Abraham and Rado and others which postulate dependency as a central and enduring cause of depression. Forty depressed women in their study failed to exhibit symptoms of dependency upon recovery. The psychoanalytic

stance that "depression equals anger turned inward" is also challenged by this study. The authors state: "Acutely depressed women show increased rather than decreased hostility" (p.211). They note that this hostility tends to be directed towards the husband and children. Millon and Klerman (1986, p.444) contributed a similar view: "Depressed mothers with infant children tend to be overconcerned, helpless, guilty, and sometimes overly hostile." If the psychoanalytic dictum were true, then the women should demonstrate decreased anger as depression increased.

Freud (1917) published Mourning and Melancholia to outline his theories of the psychodynamic genesis of depression. Freud stated that:

The distinguishing mental features of melancholia are a profoundly painful dejection, cessation of interest in the outside world, loss of the capacity to love, inhibition of all activity, and a lowering of the self-regarding feelings to a degree that finds utterance in self-reproaches and self-revilings, and culminates in a delusional expectation of punishment.
(p. 244)

Freud differentiates between melancholia and mourning:

"The disturbance of self-regard is absent in mourning; but otherwise the features are the same" (p. 244). Freud also

notes that "melancholia is in some way related to an object-loss which is withdrawn from consciousness, in contradistinction to mourning, in which there is nothing about the loss that is unconscious" (p.245). Freud describes further that the melancholic displays:

...an extraordinary diminution in his self-regard, an impoverishment of his ego on a grand scale. In mourning it is the world which has become poor and empty; in melancholia it is the ego itself. The patient represents his ego to us as worthless, incapable of any achievement and morally despicable; he reproaches himself, vilifies himself and expects to be cast out and punished. (p.246)

According to Freud, the loss of a loved person may result in normal mourning or abnormal depression. The primary difference between the two conditions is the self-depreciation of the depressed person. The mourner sees the world as impoverished, whereas the depressed person looks upon himself as impoverished. Gut (1989), a leading psychoanalyst, states that: "Subjectively, grieving differs from being depressed primarily by the clarity of images and the flood of vivid memories that are part of the pining during the experience of separation or after a loss is recognized as final" (p. 63). In contrast with grieving, depression involves a sense of dullness, a

confusion, and perplexity that interferes with our ability to take action to have our needs met.

In The Drama of the Gifted Child, A. Miller (1981), a German psychoanalyst, concluded that child rearing practices strongly contribute to adult depression. She claimed that children who grow up trying to live up to their parents' expectations recognize at a very early age that their parents' emotional needs must come first, and that they must unequivocally adapt themselves to those needs. These children understand that to remain in their parents' favour, or even to be tolerated by them, they must perform at very high levels in all endeavors, thus spending most of their youth attempting to win their parents' approval. Although many of them have successful careers in adulthood, they are plagued by depression and anxiety. When a mother or father is emotionally insecure, a gifted or sensitive child has a remarkable ability to intuitively respond to the needs of the parent and will do whatever is necessary to secure this parent's approval and love. The child is also unconsciously aware that he or she is loved only in a way that is conditional upon his or her successes, successes which reflect narcissistic glory upon the parent. The child finds it almost impossible to not comply with the demands of the parent, because the price of rebellion is complete rejection. Therefore, the

child learns to create two selves: a false self that is highly sensitive to the needs of the parent and a true self that is buried deep inside and is unconscious. A patient (A. Miller, 1981) expresses what it was like for him:

I lived in a glass house into which my mother could look at any time. In a glass house, however, you cannot conceal anything without giving yourself away, except by hiding it under the ground. And then you cannot see it yourself either (p.21).

According to this author such an experience of accomodating to a parent's needs is significant in the development of depression in adulthood.

Modern theories.

Some theorists believe that depression is caused by heredity. Others blame faulty personality development that prevents an individual from coping with specific intrapsychic conflicts or social stress. Others look to biochemical substances which disturb normal neurophysiological processes. Charney and Weissman (1988) cited the following risk factors for major depression: "being female; young, particularly ages 25-35; divorced, separated, or having marital discord" (p.55). They noted

that lack of an intimate, confiding relationship is also a risk factor for females under stress.

Senay (1973) observed that "Equifinality--the idea that there are multiple causal chains that lead to a given organismic state--constitutes a general systems theory concept...and has special relevance for depression" (p.239). He added that depression cannot be defined by its manifestation in one system alone; it must be seen as a process with expression in the biological, psychological, and sociological systems. M. M. Weissman and E. S. Paykel (1974) concurred with Senay's principle of multiple causality, stating that the aetiology of depression includes stressful life events, genetic predisposition, vulnerability to certain stresses based on personality and other factors, and biologic and neuropharmacologic abnormalities.

Life events theorists consider depression to be a psychological response to environmental stress. Paykel (1973) reports an investigation of life events experienced by 185 depressed patients in the six months immediately prior to the onset of depressive symptoms. The same information was obtained from 185 controls from the general population matched for age, sex, marital status, social class and race. Thirty-three life events were examined, and eight events occurred to a significantly

greater extent among the depressed patients. Three events clearly involve loss: marital separation, death of an immediate family member, and departure of a family member from home. In the other five events, less obvious losses occurred: increase in arguments with spouse, start of new type of work, serious illness of a family member, serious personal illness, or change in work conditions (Paykel, 1973, p. 224). C. Costello (1976) notes that "The experience of loss is one of the cornerstones of the psychoanalytic theory of depression" (p.52). Bowlby (1969), in his classic studies on attachment and separation in infancy, found that past loss is correlated with depression. He emphasized the child's need for a warm and continuous relationship, and concluded that the abrupt severing of an attachment with the caretaking person in infancy can retard the natural growth of independence and self-reliance.

The interaction of various factors predisposing a woman to the onset and the maintenance of depression at any given time has been thoroughly examined in the research conducted for more than a decade in English urban communities by Brown and Harris (1978). They used large samples of working-class women in the general population. Brown and Harris (1978) found that women lacking an intimate, confiding relationship were four times as

vulnerable to depression when encountering a threatening event or major difficulty. In their study, three other social factors seemed to contribute to the variations in depressive disorders: the presence of three or more children at home, loss of a mother before age eleven, and unemployment.

C. G. Costello (1982) replicated the above study and theorized that the premorbid personalities of the women studied made them vulnerable to depression. They were deficient in social skills, leading to a lack of intimacy and subsequent depression.

Since Freud (1917) originated the idea of helplessness, researchers have explored the possibility that helplessness is causally related to depression. The concept of learned helplessness underlies several approaches to depression, including cognitive theory (A. T. Beck, A. J. Rush, B. F. Shaw, & G. Emery, 1979), learning theory (Lewinsohn, Munoz, Youngren, & Zeiss, 1986), learned helplessness (M. E. Seligman, 1975), and attribution theory (Abramson, Seligman, & Teasdale, 1978). In the learned helplessness model, an individual experiences aversive circumstances beyond his or her control. The person comes to believe that events generalized beyond the original learning experience are outside his or her control. Because an individual

believes he or she is helpless to effect change in certain circumstances, he or she gives up trying and experiences depression with components on affective, cognitive, motivational and somatic levels. The learned helplessness theory has been since reformulated: according to M. Seligman et al. (1988), "The reformulation of the learned helplessness model of depression claims that a tendency to make internal, stable, and global explanations for bad events is a risk factor for depression" (p.13).

According to attribution theory, an internal attribution is defined as a belief that the environment cannot be controlled, and helplessness is therefore attributed to the self rather than to existing environmental conditions. The term global attribution refers to the situation in which a person generalizes the latter belief to all circumstances. Layden (1982) asserts that "...depressed individuals tend to have an attributional style of externalizing success and internalizing failure" (p.3).

Social influences.

Social influences are regarded as extremely important in understanding depression in women. As described above, social aspects such as dependence, hostility, self-esteem, and loss are central themes in the psychoanalytic

literature. Descriptive phrases such as "dependency", "overwhelming need for affection", or "hysterical involvement in feelings and relationships", have been replaced by the phrase "relational ability". Thus, behaviour that was once deemed neurotic is now seen as healthy (Caplan, 1985).

J. B. Miller (1986) has observed that women are trained to focus the better part of their attention on establishing and maintaining relationships. According to Miller:

The sense of pleasing herself has been a very rare experience for most women. When they attain it, it is a new found joy. Women often go on to find new and enhancing relationships, but if their goal is to secure the relationship first, they usually cannot find the beginning of the path. This, I believe, is because male-female relationships have been so effectively structured to deflect women away from their own reactions and fulfillment. (p.110)

Gilligan (1982, p.17) appears to be in accord with Miller: "Women not only define themselves in a context of human relationship but also judge themselves in terms of their ability to care." Women receive double messages from society, family and partners about who they are and how they should behave. When they act nurturant and

relational as they are trained to be, they are criticized as dependent. When they act assertive, they are criticized for trying to overpower men. In addition, there is a prevailing attitude that mothers' work is trivial and not worth payment for the labour. Low income women are especially vulnerable to depression due to lack of social and educational opportunities, inadequate resources in childcare, transportation difficulties, isolation, and expectations of performing as a traditional wife and mother even while working full-time.

M. Weissman and G. Klerman (1973, p. 61) conducted a content analysis of psychotherapy with depressed women. They found that the women were far more inclined to deal with practical problems than with soul searching. They noted that: "The therapist familiar with the realities of working and lower class life will not be surprised if the patient wants to talk about housing, crowding, unemployment, and extended family life rather than about interpersonal, dynamic and early experience." This study demonstrates the importance of social influences in understanding the causes of depression in women.

Theories of depression as productive.

In her book, Productive and Unproductive Depression, Gut (1989) presented her thesis that depression is a

healthy, adaptive response. She argued that depression can be viewed as "caused" by the body's attempt to alert the person that change--or a new adaptive response--is required. It is the body's way of telling us that we are in a crisis: that we must look within in order to "facilitate and protect concentration on intensified conscious and unconscious scanning, exploration, and integration of relevant experience in ways that can lead to a resolution of the internal deadlock, or to the recognition that the situation cannot be changed" (p. 1). As a result of "productive depression", Gut surmised, "useful learning or maturation has occurred, some behaviour has been reorganized, some plan revised, so that following the depressed episode we function more effectively in the attainment of some goal, or become more realistic in setting our goal" (p. 2).

Sartre (1962) would agree with Emmy Gut's thesis that one needs to take time to contemplate one's life when suffering a loss. Sartre described how a bereavement or termination of a relationship can destroy the accustomed conditions or structure in our lives. We are reluctant to live without that structure. He noted:

My melancholy is a method of suppressing the obligation to look for these new ways by transforming the present structure of the world, replacing it with

a totally undifferentiated structure. What it comes to, in short, is that I make the world into an affectively neutral reality, a system which is, effectively, in complete equilibrium. It is my experience that depression causes us to slow down and be introspective thereby neutralizing the world around us until we can restore a semblance of the structure life had before or else gain new meaning from it (cited in C. Costello, 1976, p. 114).

Gut (1989) outlined five phases in the formation of an episode of depression. In the first phase, we use our body, mind, skills and interpersonal responses to achieve a significant goal, consciously or unconsciously. In the second phase, we experience perplexity and helplessness when our efforts towards our goal are stymied. In phase three, there is an intense, and for the most part unconscious, preoccupation with attempts to solve the dilemma. As a result of the disquieting feelings of disequilibrium and urgency, we develop, in stage four, unconscious efforts to look for new solutions. Symptoms that predominate at stage four include disturbances of sleep and appetite, inexplicable exhaustion, lethargy and introspection. Phase five allows for more intensive information processing, providing that depressed reactions are not suppressed with medication, alcohol, narcotics or

restless activity. The information processing leads to two things: comparison and integration of fresh perception with earlier perceptions stored in our memory; and, comparison and integration of recent conclusions with long-established beliefs. Values and expectations are also integrated.

Gut further noted that depressed reactions allow easier access to unconscious processes. For example, disturbed sleep and dreams provide clues to the cause of our depression. As a consequence, "The conscious or unconscious sense of dysfunction subsides and with it the symptoms of depression" (p. 33). Gut is in the forefront of the theorists who believe that there are many positive aspects of depression. Winnicott (1964, p. 26) claims that a person may come out of depression stronger, wiser and more stable than he went into it.

Treatment

Psychotherapists strive to hasten the patient's recovery by providing emotional support and reassurance, opportunity for ventilation of feelings, dealing with the consequences of depression, and prevention of further episodes. They focus on the maladaptive patterns or early antecedents that predispose patients to depression and

they apply the technique of cognitive restructuring to prevent further episodes.

In order to be effective in treating depression it is critical to make a careful mental and physical diagnosis by investigating the following: (a) history of sexual and physical abuse; (b) prescription drug utilization; (c) past and current medical conditions; (d) reproductive life history (menstruation, birth control, pregnancy, abortion and menopause may contribute to a woman's depression).

Treatment for depression has consisted mainly of psychological intervention combined with antidepressant medication. The major psychological treatment modalities currently used in treating depression include the following: psychodynamic therapy, cognitive-behavioural therapy, interpersonal therapy, family and marital therapy, pharmacotherapy, electroconvulsive treatment, phototherapy, and group therapy.

Psychodynamic Therapy

Psychodynamic therapists investigate early childhood loss or trauma, damaged self-esteem resulting from the discrepancy between the actual self and the ego ideal, narcissistic rage, feelings of hopelessness and helplessness, and problems with autonomy and intimacy.

The goal of psychodynamic therapy is to effect a change in personality structure or character, and not simply to alleviate symptoms. Some of the strategies and techniques used in psychodynamic therapy are: active interpretation of the transference, identification of and emphasis on a specific dynamic focus, active collaboration between the patient and therapist, and discouragement of regression. The term transference comes from the psychoanalytic school and is defined as:

...the process by which a patient comes to feel and act towards the therapist as though he were somebody from the patient's past life, especially a powerful parent. The patient's transference feelings may be of love or of hatred, but they are inappropriate to the actual person of the therapist. (Concise Medical Dictionary, 1987)

Contemporary approaches differ from traditional psychodynamic practice in three distinct ways: (a) the treatment is shorter; (b) the therapist plays a more active role; and, (c) the therapist has a more direct approach (Karasu, 1990).

Cognitive-Behavioural Therapy

Cognitive-behavioural therapy was developed by (A. T. Beck et al., 1979). It is a short-term, structured therapy in which the patient and the therapist collaborate to identify and test negative cognitions, to develop more flexible schemas, and to learn new cognitive and behavioural responses. The main tenet of cognitive behaviourists is that depression can be alleviated by changing negative thought processes or learned "errors" in thinking that lead a person to see himself or herself as worthless, the world as hostile, and the future as hopeless. Cognitive therapy is best applied, according to state-dependent learning research, during depressed periods. What one learns in a particular state, such as depressed, is more likely to generalize to that specific state at another time. A therapist using Beck's treatment investigates empirically the patient's automatic thoughts, inferences, conclusions, and assumptions. The therapist and patient explore and correct the perceptual distortions. As a result, the depressed person learns which responses produce positive reinforcement and which elicit negative reactions.

Social Learning Therapy

Lewinsohn et al. (1986) also take a behavioural approach to treating depression, using social learning theory. Social learning theory posits that psychological functioning can best be understood in terms of continuous reciprocal interactions among personal factors, behavioural factors, and environmental factors, all operating as interdependent determinants of one another. In other words, people are capable of exercising considerable control over their own behaviour, not just as reactors to external influences. Lewinsohn et al. contend that a low rate of response-contingent positive reinforcement is causally related to all depressions. Therefore, they treat depression by restoring an adequate schedule of positive reinforcement. This is achieved by altering the frequency, quality, and range of the depressed person's activities and social interactions.

Interpersonal Therapy

Interpersonal therapy (G. L. Klerman, M. M. Weissman, & B. J. Rounsaville, 1984) emphasizes the interaction between the individual and the psychosocial environment and usually combines short-term psychotherapy (usually

from twelve to sixteen weeks), and medication. Therapists stress that solving of interpersonal problems requires supportive and behavioural strategies as well as educating patients about the nature of depression. Therapists investigate the immediate social context of the family, friends and co-workers of the person suffering from depression, and strive to increase self-esteem and improve communication. In Freudian tradition, interpersonal therapists link adult emotional life to childhood emotional bonds. Interpersonal therapy may be especially helpful for women due to its emphasis on relationships and the development of better relationship skills as a core source of empowering women.

Family and Marital Therapy

...the family therapist is always in the presence of shifting images. Often he focuses on one well-defined piece--the family's presentation of their identified patient. But there are hundreds of other pieces with clear or uneven edges that have to be fitted together in order to see the pattern, and perhaps change the position of the pieces. (Minuchin, 1984, p. 7)

Women often become depressed as a result of conflicts or disruptions in their marriage or family relationships. The depression can exacerbate any problems in the family, according to Friedman (1975) and Gelfand (1990). Married couples with one depressed member typically show dysfunctional patterns of husband-wife interactions. This has been assumed to be due to the presence of the depressed individual in the marriage. By observing married couples' interactions when dealing with a variety of issues, Schmaling and Jacobson (1990) found that the level of marital distress, rather than the presence of a depressed individual, was responsible for dysfunctional interactions. Russo (1985, p.7) claims that "Marital difficulty is the most commonly reported event in the six months prior to the onset of depression and the most frequent problem presented and discussed by depressed women in outpatient treatment."

I believe that family therapy is a good approach for repairing damaged relationships and for alleviating depression related to such relationships. Family and marital therapy focuses on the family as a system emphasizing relationships rather than individuals and views positive changes in the functioning of the system as beneficial to individual family members. Family therapy encompasses several schools of thought. One is

psychoanalysis, in which the therapist helps the family members to analyze their unconscious needs and wishes which might be disrupting family functioning. Family therapists will also try to resolve conflicts and losses in the patient's original family (Ackerman, 1984). A second school, strategic family therapy, focuses on solutions to specific problems within the context of the existing family hierarchy (Boscolo, Cecchin, Hoffman, & Penn, 1987; Haley, 1987; Madanes, 1981). A third school is the system-oriented family therapies in which the complex interaction matrix of the family is the focus of treatment (Bowen, 1978). A fourth school, experiential therapy, emphasizes clear, direct communication, and focuses on individual and family growth through shared experience (Whitaker & Bumberry, 1988). The fifth school, structural family therapy (Minuchin, 1984), stresses reorganizing the family structure to disrupt dysfunctional patterns of behaviour and to create clear, flexible boundaries.

Group Therapy

As a result of the breakdown of community and family in our society, group therapy has developed an important role as a substitute family. Depressed women need group

experience that replicates the family and teaches relationship skills. Members experience a reenactment of their everyday problems, and they learn new methods of dealing with them. Participants learn that although their circumstances may differ, their pain and struggles are universal (I. D. Yalom, 1985). Group therapy provides members with the opportunity to assess themselves, validate their experiences and perceptions, attempt personal, behavioural and attitudinal changes, express feelings, and receive feedback. Some of the therapeutic aspects of group therapy include: learning that others have similar concerns, feeling accepted by the other group members, and telling one's story. Goals of group therapy include the following: (a) to improve interpersonal relationships, (b) to increase autonomy, (c) to develop self-respect and self-confidence, (d) to become more honest and direct, (e) to learn how to communicate more effectively, and (f) to find ways of resolving personal problems (Fuhriman & Burlingame, 1990).

Phototherapy

Phototherapy is the treatment of choice for individuals suffering from seasonal affective disorder (SAD). Seasonal affective disorder is defined by McGrath,

Keita, Strickland, and Russo (1990) as "a cyclic illness characterized by recurrent episodes of depression in fall/winter alternating with periods of euthymia (normal mood) or hypomania (mild elation and behavioural activation) in spring/summer" (p. 61). Phototherapy involves exposing depressed individuals to very bright fluorescent light or incandescent light two times a day. "Although the mechanism of action of phototherapy is yet to be elucidated, there are some empirical data to support both circadian phase-shifting theories and photon-threshold theories" (Lam, Kripke, & Gillin, 1989, p.145). A number of studies have confirmed the efficacy of phototherapy in treating SAD patients (Lam et al., 1989; Rosenthal et al., 1984).

Somatic Forms of Therapy

*Presently she cast a drug into the wine...to bring
forgetfulness of every sorrow....*

--Homer's Odyssey

Although revolutionary advances in pharmacotherapy have been instrumental in reducing morbidity and mortality, these potent medications are not the final solution in the treatment of depression. Most of them are

efficacious in certain subtypes of depression, primarily endogenous, but they have several drawbacks. They are ineffective for a great number of people who suffer from depression. They have a delayed onset of antidepressant action from two to six weeks. They have significant side effects, such as dry mouth, weight gain, sedation, constipation, heart rhythm disturbances, headaches, nausea and loss of sexual desire (Kaplan & Sadock, 1985). Furthermore, they are lethal in cases of overdose. Prozac, also called fluoxetine, is an example of an antidepressant. Described as the wonder drug for depression, in the past few years it has become one of the most prescribed and best-selling drugs to treat depression. The reason for Prozac's success is that it has fewer side effects than other antidepressants. However, the following side effects are considerable: headaches or nausea, insomnia, loss of sexual desire and suicidal ideation. A major problem with Prozac was recently discovered by Dr. Martin Teicher, an associate professor of psychiatry at Harvard. He reported that six of his patients "developed intense, violent, suicidal preoccupation after two to seven weeks of fluoxetine treatment" (Grady, 1990, p. 64). Reliance on drugs as the preferred treatment for depression overlooks the contribution of social and cognitive factors to the origin

and persistence of women's symptoms. Women are twice as likely as men to suffer from addiction to prescription psychotropic drugs (Ogur, 1986). According to Rodin and Ickovics (1990), "Even when women are the primary users of a class of drugs, most studies exclude women" (p. 1027). McBride (1987, p. 35) states that "More than 70 percent of all prescriptions for psychotropic drugs are written for women, although women are typically unrepresented in the early stages of clinical drug testing and, not coincidentally, experience more drug side effects." A little known side effect of psychotropic therapy is tardive dyskinesia. Kaplan and Sadock (1985) define tardive dyskinesia as "a hypermotility of facial muscles and the extremities" (p. 50). It occurs as a result of long-term psychotropic therapy or after the discontinuation of such therapy (Sachdev, 1989).

Another form of somatic treatment is electroconvulsive therapy (ECT). Electroconvulsive therapy is generally reserved for patients resistant to antidepressant therapy or for those with medical contraindications to antidepressant drugs. Persad (1990) claims that electroconvulsive therapy has been in use for over fifty years and has remained one of the most effective treatments in psychiatry especially for the affective disorders. In his article, Persad states that

the effectiveness rate for ECT in depression ranges from 80 to 90 per cent, and that it is especially effective for the more severe forms of depression and for those patients who have not responded to other interventions.

The side effects associated with ECT include disruption in thinking and memory immediately following an ECT treatment. Some patients report losing memories for events that occur for both a few months before and after treatment. The severity and length of these difficulties in learning and remembering vary considerably with each individual and with how the treatment is performed. According to an article in the Scientific American (Managing major psychiatric, 1988, p.7): "its only absolute contraindication is increased cranial pressure." However, they note that to minimize impairment, ECT should be given to the nondominant hemisphere whenever possible. Schroeder, Krupp, Tierney, and McPhee (1990, p.727) note that: "electroconvulsive therapy has consistently been more effective than the antidepressant groups of drugs, particularly for involutional depressions." They add: "Convenience, expense, and public opinion have been major limiting factors in the use of electroconvulsive therapy."

Prognosis

The prognosis for those suffering from major depression is discouraging. Sargeant, Bruce, Florio, and Weissman (1990) discovered that the "evidence from outcome studies of major depression indicate a high rate of relapse and chronicity, recurrent episodes, and the presence of psychosocial stressors are associated with a poor outcome" (p.519). Data suggest that depressed patients who also have personality disorders respond more poorly to treatment, are more prone to suicidal ideation and suicide attempts, and are at higher risk for psychiatric hospitalization than are others who are depressed (Farmer & Nelson-Gray, 1990). Charney and Weissman (1988) state that "between 50 percent to 85 percent of patients seeking treatment for a major depressive episode will have at least one recurrence in their lifetimes" (p.60).

The importance of social factors in the aetiology of depression has been demonstrated above. The logical implications for therapists in the treatment of depression can be assumed to be the following: therapists should challenge female role stereotypes, teach clients to develop self-reliance, teach them to explore and express anger, teach assertion, teach them to nurture themselves

and help them to form supportive alliances with other women.

Much remains to be learned about the aetiology, nature, and treatment of depression. The search for effective treatments of affective disorders has continued uninterrupted throughout human history. Despite recent progress, optimal diagnoses and treatment have yet to be achieved.

REVIEW OF RESEARCH ON DEPRESSION IN WOMEN

What follows is a review of the literature on research on depression in women, with an emphasis on articles published between 1985 and 1990. For the purposes of this paper, all terms relating to depression are defined according to DSM-III-R (American Psychiatric Association [APA], 1987).

Research Methods

Research methods for the study of depression include comparative treatment strategies, case-studies, longitudinal studies, cross-sectional studies, experimental studies, and qualitative studies. Each of these methods will be discussed in respective order, except for qualitative studies, reviewed in the Method chapter. First, comparative treatment strategies will be discussed.

Comparative Treatment Strategy

In comparative treatment strategies, two or more treatments are compared in order to discover which is most effective for a particular clinical problem. Standardized

procedures are used for selection of subjects and for evaluating the response to treatments. A good example of a comparative study is the one conducted by Rush, Beck, Kovacs, and Hollon (1977) to evaluate cognitive therapy and pharmacotherapy for depressed outpatients. Cognitive therapy patients received individual therapy in order to identify and change negative thought processes that lead to depression. Pharmacotherapy patients received imipramine, an antidepressant. Both treatments were conducted over a twelve week period. There was a significant improvement in depressive symptoms for both forms of therapy over the course of a year. The cognitive therapy treatment was found to be superior.

One of the problems in performing comparative treatment research is the difficulty in differentiating treatment techniques (Elkin et al., 1989). A number of important variables, such as amount, duration, and frequency of treatment, must be held constant. The behaviour of therapists and treatments provided by them must meet established criteria. The treatments need to be administered uniformly. It is not acceptable for one therapist to take a directive approach, and another an empathic approach. Unfortunately for the researcher, it is necessary in treating individuals who are depressed to

be flexible in clinical judgement, and to use interventions appropriate to the situation.

A second problem with the comparative method is investigator bias. An investigator may administer a favoured treatment with more enthusiasm and consistency than other treatments. A. Kazdin (1986, p.28) cites Smith et al., who conducted a meta-analysis of comparative studies: "evidence suggests that the treatments to which investigators show allegiance yield greater therapeutic change (larger effect sizes) than those to which they are opposed or neutral."

A third problem with comparative treatment studies concerns the validity of outcome findings for different treatments. Despite the claims that cognitive-behavioural treatment is most effective (A. Beck, S. Hollon, J. Young, R. Bedrosian, & D. Budenz, 1985; Reynolds & Coats, 1986; Rush et al., 1977; Teasdale & Fennell, 1982), it appears that there are negligible differences in effects produced by various treatments. In fact, Rude and Rehm (1991) posit, in a review of the literature on cognitive and behavioural treatments for depression, that patients with greater behavioural deficits actually benefited the least from these approaches. Stiles, Shapiro, and Elliott (1986, p.165) suggest that:

Despite the plethora of purportedly distinct psychotherapeutic treatments, influential reviews of comparative outcome research together with frequently cited studies appear to support the conclusion that outcomes of diverse therapies are generally similar.

Case Study

The case study, or the intensive study of the individual, has played a central role in clinical psychology. Understanding the individual is the sine qua non of doing psychotherapy. The case study method has a distinguished history originating with Kraepelin and Freud. The case study can serve several valuable functions, such as: casting doubt on general theories, generating hypotheses about treatment, evaluating unusual cases, and providing opportunities for new applications of existing treatments (A. E. Kazdin, 1982). Further advantages of the case study method are outlined by C. Hill, J. Carter, and M. O'Farrell (1983): first, it permits a better description of what actually happens between counsellor and client. Second, positive and/or negative outcomes can be understood in terms of process data. Third, the unique qualities of the counsellor-client relationship and the change process can

be highlighted. Finally, measures can be tailored to the specific problems of the client. Despite its recognized heuristic value, the case study is considered to be inadequate as a basis for drawing scientifically valid inferences. Uncontrolled case studies characteristically rely on the therapist's subjective account of what occurred. Most experimental research is open to the public domain, allowing for replication, yet the clinical situation is protected from public scrutiny by caveat of confidentiality. Therefore, it is impossible to check the researcher's data, interpretations, or conclusions (Shulman, 1990). In the case study, the researcher must include data from other sources (client and significant others) and must use standardized measures in addition to subjective data. The remedy is to use single case research designs to permit inferences to be drawn about intervention effects by utilizing the patient as his or her own control. The impact of treatment is examined in relation to changes in the patient's progress over time. Two informative case study designs related to depression in women are reported by C. Hill et al. (1983) and O'Farrell, Hill, and Patton (1986).

Longitudinal and Cross-sectional Study

Two methods used to study depression in women are the longitudinal and cross-sectional approaches. In the former, an individual or a group is studied over a period of time. In the cross-sectional approach, a representative segment of the population to be studied is analyzed at different times. An advantage of the cross-sectional approach is one of economy, since researchers can complete their investigations as rapidly as they can collect and analyze their data. The longitudinal approach is a type of "repeated measures" design. A weakness of the cross-sectional approach is the assumption that groups selected at different ages are comparable. The longitudinal approach employs the same subjects over and over again, yielding identical groups for comparison. Some examples of longitudinal and cross-sectional studies will be discussed later in this paper (Duggan, Lee, & Murray, 1990; Rorsman et al., 1990; Segal, Shaw, & Vella, 1989; Waldron & Herold, 1986).

Experimental Study

The final research method I will discuss is the experimental approach. A large number of treatment

outcome studies have used randomized clinical trials to compare various treatments with each other and with control groups. Randomized clinical trials have been controversial for the following reasons: different treatments have yielded comparable outcomes; the studies are complex, time consuming, and expensive; methodological issues limit the validity and generalizability of the findings; and, it is difficult to organize a coherent program of sequential trials (A. Kazdin, 1986).

Experimental group designs appear to offer the most scientific procedures for generating data about treatment for depressed women, because they are replicable; they use objective measures; they are more economical in researcher's time and effort than many methods; and, they can approximate the greater population through random sampling. Some weaknesses of experimental group design relevant to women and depression are: problems with pre-test and post-test reliability, experimenter bias in administering treatment protocols, inability to gain true random sampling, lack of generalization due to the inability to control for all variables (especially subtle experimenter bias), and lack of reliability in diagnosis.

There are a number of ethical problems involved in experimental group design. Methods used to obtain a control group, such as waiting lists, non-specific

attention, and minimal personal contact, may compromise the needs of the patients involved, and are especially risky for depressed patients. Imber et al. (1986, p.138), in discussing research on psychotherapy and pharmacotherapy of depression, emphasize the need to achieve a balance between "ensuring the safety of subjects and establishing the value of a therapeutic approach in adopting an appropriate control condition." Another area of ethical concern is that of placebos and placebo control groups. Sources of possible harm include "discomfort" due to deception, the deterring of patient-subjects from seeking active treatment, and frustration for subjects who fail to improve (Imber et al., 1986).

I believe that clinical trials have important advantages over analogue research with regard to treatment outcome studies of depression. Analogue studies are usually conducted in a laboratory or academic setting, whereas clinical studies take place in a hospital or clinic. Patients diagnosed as depressed tend to exhibit more severe symptoms in a clinical setting compared to student volunteers at a university. Second, students treated in analogue research studies may be recruited as participants in the study with incentives such as course credit and money. In a clinical trial, the subjects consist of patients in a hospital or clinic who are

seeking relief from their pain. Third, subjects in analogue studies may not be motivated to the same extent to gain relief from depression as a patient who is actively seeking treatment. Fourth, clinical trials are conducted by professional therapists, whereas graduate or undergraduate students may assume the role of therapist in analogue research. Finally, treatment in analogue research is standardized. Subjects in clinical treatment groups receive a more individualized approach.

Analysis of Research Findings

The primary research methods for the study of depression in women have been described above. What follows is a more detailed analysis of research findings in this field.

General awareness of the personal and social impact of depression has increased during the latter part of the twentieth century (G. Klerman, 1989). Correspondingly, theoretical explanations and empirical investigations have proliferated. However, the empirical validation of therapeutic models remains elusive. In the case of most schools of therapy, the lack of quantitative data derived from controlled and replicable designs makes their theoretical concepts vulnerable to intense criticism

(Corsini & Wedding, 1989). One exception to the general lack of empirical data is the plethora of studies on the use of drug and behavioural treatments in depression. First I will examine reports in the literature which support the use of cognitive or behavioural techniques. Then I will review reports on family therapy, developmental studies, life events, work role, longitudinal studies, and group therapy.

Cognitive-behavioural Studies

Rush, Khatami, and Beck (1975) reported the treatment of three patients with chronic depression using a combination of cognitive and behavioural techniques. The main behavioural technique consisted of activity schedules. The main cognitive technique was to expose and correct the patient's distorted perceptions of the activities undertaken. These patients showed prompt and sustained improvement with therapy, as reflected by their scores on clinical and self-report measures.

The role of cognitions in causing mood swings was examined in two studies in which patients were given therapy. In a case report of a single subject, Peterson, Luborsky, and Seligman (1983) found that attributions in therapy sessions predicted mood swings. Teasdale and

Fennell (1982) used a within-subjects design to investigate the role of cognition in patients with chronic depression. They systematically varied the therapist's role: in one variation he/she attempted to change depressive thought; in the other he/she simply helped the patient to explore the depressive thought. According to subjects' self-reports, depressed mood was reduced when the therapist attempted to change cognitions, while thought exploration produced minimal change. This data is consistent with earlier studies by Teasdale and his colleagues. They have shown that the mood of depressed patients deteriorates when patients are instructed to think negative thoughts (Teasdale & Bancroft, 1977). Mood improves when depressed patients are sufficiently distracted in order to reduce the frequency of their negative thought (Teasdale & Rezin, 1978).

The social interaction theory of depression postulated by McLean (1976, 1981) also incorporates behavioural and cognitive techniques. McLean considers the interaction of the depressed person with his or her social environment to be the crucial factor in the development or reversal of depression. In a large-scale outcome study by McLean and Hakstian (1979), one hundred seventy-eight moderately depressed patients were selected by screening interview and psychometric criteria.

Subjects were randomly assigned to one of four treatment conditions: first, behaviour therapy which included marital therapy, coping skills training, social skills training, and cognitive therapy; second, short-term traditional psychotherapy; third, relaxation training; and fourth, medication (amitriptyline). Therapists were selected on the basis of their preferred treatment. Patients encouraged their spouses or significant others to participate in treatment sessions. Treatment consisted of ten weeks of one session per week. The results obtained demonstrated the unequivocal superiority of the behavioural intervention. Behaviour therapy was most effective on nine out of ten outcome measures immediately after treatment, and marginally superior at a three-month follow-up. The traditional psychotherapy treatment proved to be the least effective at both the post-treatment and follow-up evaluation periods.

In a similar study, Elkin et al. (1989) investigated the effectiveness of two brief psychotherapies: interpersonal psychotherapy and cognitive behaviour therapy. Their research was conducted with outpatients diagnosed with major depressive disorder using the Research Diagnostic Criteria (RDC) (Spitzer, Endicott, & Robins, 1978). Two hundred and fifty patients were randomly assigned to one of four 16-week treatment

conditions: interpersonal psychotherapy, cognitive behaviour therapy, imipramine hydrochloride plus clinical management, and placebo plus clinical management. The clinical management component provided guidelines for the management of medication and side effects, and reviewed the patient's clinical status. It also provided the patient with support, encouragement and, if necessary, advice. Patients in all treatments showed significant reduction in depressive symptoms and improvement in functioning over the course of treatment. At termination, the treatment that was most effective was imipramine plus clinical management. The two psychotherapies followed close behind. There was no evidence that the psychotherapies differed in effectiveness. The placebo plus clinical management proved least effective.

Social cognitive factors have come to play an increasingly important role in models of depression. For instance, A. T. Beck, A. J. Rush, B. F. Shaw, and G. Emery (1979) have suggested that the negative thinking so common in depression contributes both to its severity and persistence. In the attributional reformulation of the learned helplessness model, Abramson, Seligman, and Teasdale (1978) conceptualize depression in terms of a pattern of interpretation of environmental events that results in negative emotional experiences. The

reformulated helplessness model of depression posits that internal, stable, and global causal attributions for negative life events are contributory causes of depression (Layden, 1982). Consistent with this theory, depressed and nondepressed individuals have been found to differ in attributional styles. Depressed individuals have been reliably found to make internal, stable, and global attributions for negative events and external, unstable and specific attributions for positive events; what happens with nondepressed individuals is the opposite. This has been demonstrated in a wide variety of studies (Crocker, Kayne, & Alloy, 1988; Dent & Teasdale, 1988; Heimberg, Vermilyea, Dodge, Becker, & Barlow, 1987; Robins, 1988; M. Seligman et al., 1988).

Family Therapy

There appear to be few good studies of depression and family therapy; however, the one reviewed here deserves examination. Marital and family therapists examine the role of the depressed member within the context of the psychological well-being of his or her family; they also examine the role of family members in the maintenance of depression (Kaplan & Sadock, 1985). Friedman (1975) designed a study to assess the effectiveness of

amitriptyline and marital therapy, administered separately and in combination. Amitriptyline is an antidepressant drug that has a mild tranquilizing action (Concise Medical Dictionary, 1987). It was a random-assignment, placebo-controlled, 12-week clinical trial of 196 patients with a primary diagnosis of depression (including 172 diagnosed with neurotic or reactive depression, 15 with psychotic depression, and 9 with either manic-depressive psychosis or involutional psychotic reactions). Outcome was assessed according to the following: symptom severity, global improvement, family and marital relations, and attitudes toward medication. Results indicated that both drug and marital therapies had beneficial effects compared to their respective control treatments: (a) placebo drug and minimal contact, and (b) individual therapy. Drug therapy was associated with significant early improvement in clinical symptoms, while marital therapy was associated with significant long-term positive changes in patient self-report measures of family role-functioning and marital relations.

Developmental Studies

Developmental studies deserve mention. In order to gain a developmental perspective on depression, Stehouwer,

Bultsma, and Blackford (1985) studied a random sample of twenty-five female adolescent and twenty-five female adult psychiatric inpatients. The researchers analyzed differences in cognitive-perceptual distortions between adolescent and adult females. Each subject received a diagnosis of neurotic or reactive depression based on the DSM II nomenclature. Each subject completed the Beck Depression Inventory (BDI) (A. T. Beck, 1967). For both adolescent and adult females, self-dislike and a sense of failure were significant predictors of the BDI score. The symptoms of the adult women, such as guilt, pessimism, and insomnia, suggest an internal focus; in other words, they tend to perceive themselves as failures in their own eyes. The adolescent symptoms included perceptions that they were unacceptable, revolting, ugly or failures. These adolescents also had suicidal feelings. The experience of the adolescents suggests an external focus; that is, they perceive themselves as failures in the eyes of others. The authors found that individual therapy for the purpose of altering self-perceptions is appropriate for adult women. However, group psychotherapy is recommended for adolescents because of their external orientation. Corey and Corey (1987, p.284) note that group counselling is especially suitable for adolescents because it allows them to do the following: express and experience their

conflicting feelings, discover that they are not unique in their struggles, openly question their values, and modify values they find wanting.

In another developmental study, McNeil and Harsany (1989) sought to discover the following: (a) whether depression is qualitatively different in older and younger adults; and (b) if depression in old age is influenced more by poor physical health than other predictors. The authors found that older adults experience depression more somatically than younger adults. Depression in old age is more strongly related to poor physical health than other predictors of depression. For younger ages, predictors such as social support or stressful life events show stronger correlations with depression than poor physical health. McNeil and Harsany reported that several studies found that, despite positive outcomes, older people do not improve as much with traditional psychotherapies as younger people. Furthermore, in the studies reviewed, approximately half of the depressed elderly subjects who participated in traditional psychotherapy remained depressed following treatment. They noted that in order to effectively treat the elderly, a health psychology approach should be taken. This approach might include increasing exercise, improving nutrition and weight control, reducing cigarette and alcohol consumption,

improving sleep habits, pain control, and adhering to medication regimens.

Life Events

In their process and outcome study, Goldfried, Greenberg, and Marmar (1990) note that: "Randomized clinical trials--comparisons among contrasting treatments or between treatment and control groups--remain a major focus of activity in psychotherapy research" (p.661). Yet randomized trials neglect to take into account "interpersonal problems". These authors relate that the "vulnerable individual lives in a social system in which chronic interpersonal stressors are present, typically in the form of highly controlling relatives" (p.667).

I believe that women are disproportionately represented in depression statistics because of their life events that make them vulnerable to depression. Life events theorists as a group agree that depression is a psychological response to environmental stress, although they differ in opinion about the specific stressors. Some focus on events preceding onset, while others are more concerned with social roles or pervasive social conditions that may have an impact on a person.

The following twin study of depression in women exemplifies the importance of life events. Kendler, Neale, Kessler, Heath, and Eaves (1992) conducted a cross-sectional study designed to separate environmental from genetic contributors to major depression. They used nine diagnostic instruments to assess a nonclinical sample of 1,033 pairs of twin women for the presence of depression. Kendler et al. (1992) used a computer modeling scheme that compared the symptoms of monozygotic and dizygotic pairs, while controlling for the similarity of the twins' environment. These researchers concluded that thirty-three percent to forty-five percent of the risk for major depression results from genetic factors. This heritable risk is roughly equivalent to the genetic contribution found in coronary heart disease, stroke, and peptic ulcer, but is considerably lower than the genetic contribution to schizophrenia or bipolar disorder. However, Kendler et al. (1992) indicated that the environment is a stronger contributor to the development of major depression than is heredity. Their research suggests that events in the woman's specific environment that are unique to her, rather than events in the common family environment, especially predispose her toward depression. Therefore, stressful life events contribute to the risk of major depression.

Schafer (1985) performed a study which exemplifies the importance of life events. In order to study the effects of marital role problems and self-concept on depressed women, he used a causal model based on path analysis. The author proposed that marital role disagreement and the reflected self-concept would cause wives' depressed mood. Interaction problems were measured according to four roles defined as cooking, housekeeping, companionship with spouse, and caring for the children. Role disagreements were measured by asking the subjects to indicate how often they disagreed about these four roles. They were directed to use the following responses: never, seldom, sometimes, frequently, and very frequently. Schafer found that the wives had a negative self-concept as a result of role-disagreement experienced by both spouses. He posited that the wives would consequently experience a depressed mood. The key variable in his path model is wives' perceptions of husbands' evaluations of them. The disagreement over roles in a marriage becomes more meaningful in its impact on these wives' depressed mood when it is evaluated as leading the wives to assume a more negative assessment of themselves by their husbands. A weakness of the study is that the measures used for both the role disagreement and the depressed mood are not

standard instruments and their test-retest reliability is questionable.

The latter two studies lend credence to the life events theorists such as Paykel, Myers, and Dienelt (1969). They discovered that psychiatric patients reported that the life event most frequently preceding the onset of depression is an increase in arguments with the spouse. Also, M. M. Weissman and E. S. Paykel (1974) noted that the persistence of marital difficulties after clinical remission was found to be associated with less symptomatic improvement at discharge, and with a greater likelihood of relapse. Life events theorists Brown and Harris (1978) conclude, after analyzing the results of a number of studies, that the lack of an intimate, confiding relationship increases an individual's vulnerability to depression.

Ghaziuddin, Ghaziuddin, and Stein (1990) investigated the prevalence of life events in recurrent depression. They compared forty patients with recurrent episodes of depression with thirty-three who were experiencing their first depressive illness. Thirty of the first-episode cases experienced, prior to the onset of illness, life events such as: marital separation, serious personal illness or a change in work conditions. On the other hand, only twenty of the recurrent group gave such a

history. Patients with a first episode had an average of 2.2 life events in the six months prior to onset, whereas recurrent patients experienced an average of only 0.8 events. The results of this study lead one to believe that patients with recurrent depression are susceptible to illness at lower levels of stress than are first-episode patients. The cause of recurrent depression is a subject of great importance since most admissions to hospitals for depression are for recurrent illness.

Roehl and Okun (1984) tested the hypothesis that significant life events in women re-entering college are positively correlated with symptoms of depression. They used a random sample of 322 returning female students who were 25 years or older and who had not attended college during the previous two years. According to the interactionist life event perspective, the impact of life events is determined by how they are evaluated by the individual, and by personal and environmental factors. This study demonstrated that negative life events and lack of family social support had small but significant main and interactive effects on the depressive symptoms of these women. The implications for counselling and therapy are that life events and social support must be assessed and utilized in treatment.

Psychosocial studies of depression have consistently indicated a significant association between stressful life events and depression (M. M. Weissman & E. S. Paykel, 1974). Hammen, Ellicott, and Gitlin (1989) investigated whether negative life events would have an effect on depression when they were construed as relevant to the self. They discovered, in a longitudinal follow-up study, that patients' worst period of depressive symptoms was related to the occurrence of a preponderance of life stress in accordance with an individual's depressive personality characteristics.

Work Roles

There have been several studies in the past few years linking women's mental and physical health to their work roles. Verbrugge (1986) suggests that low quality work roles, such as those with time constraints, irregular schedules, and low control over work tasks, may jeopardize health. High quality roles, even if they are numerous, may maintain or enhance health.

Contrary to the belief that the more high-powered a woman's career, the more dangerous to her well-being, the evidence indicates that women in occupations with higher status obtain psychological advantages (Perry-Jenkins,

Seery, & Crouter, 1992; Repetti & Crosby, 1984; Verbrugge, 1986). Waldron and Herold (1986) analyzed the relationships among employment status, attitudes toward employment, and women's health. They found that health is related to the agreement between a woman's actual role and her ideal role. The findings are consistent with the person-environment fit theory, which postulates that a discrepancy between desires, attitudes, or capability and environmental circumstances, can have negative effects on health.

Women and men have always had multiple roles. However, women experience greater inter-role conflict and overload from demands on their time and energy than do men (Rodin & Ickovics, 1990). One key difference appears to be women's greater family responsibilities. Even when both spouses work, wives perform a disproportionate share of child care and household tasks, regardless of social class (Scarr, Phillips, & McCartney, 1989). The latter researchers stress that working mothers need social supports such as parental leave, spouse support, child care and better wages.

Longitudinal Studies

The Stirling County Study (Murphy, 1990) is a noteworthy longitudinal investigation of psychiatric epidemiology. It began in 1952 and followed the course and outcome of depression and anxiety disorders in the general population of Stirling County, Nova Scotia. The study encompassed a sixteen year period. A computer program called DEPAX was used for subject interviews. DP stands for depression and AX for anxiety. Murphy (1990) has noted several important findings that have emerged from this study. These are: (a) the current prevalence of depression is from four to six percent; (b) most depressed people do not receive treatment from psychiatrists; (c) women were significantly different from men in that they were more likely to have discussed their symptoms with a doctor; (d) twice as many women as men had a DEPAX disorder (sixteen percent compared to eight percent); (e) there was a supposition that men may drink alcohol as an equivalent to women becoming depressed, bearing in mind that there was very little comorbidity between alcoholism and depression; (f) the mortality risk for the DEPAX types of disorders were found to be 1.5 times the expected number of deaths over the subsequent sixteen years; (g) there is also a significant sex

difference for the mortality ratios (twice as many men died); and (h) the prevalence of depression varies inversely with socioeconomic status. The results of the Stirling County Study indicate that depression leads to increased numbers of deaths and an increased chronic or recurrent course of illness.

Rorsman et al. (1990) undertook a longitudinal study in Sweden from 1957-1972. They discovered that the annual age-standardised first incidence of depression was found to be 4.3 per 1000 person years in men and 7.6 per 1000 person years in women. Up to seventy years of age, the cumulative probability of suffering a first episode of depression was twenty-seven percent in men and forty-five percent in women.

Andrews, Neilson, Hunt, Stewart, and Kiloh (1990) began a longitudinal investigation in 1965 to study the classification of depression. Their subjects were two hundred and twelve patients diagnosed with either endogenous or neurotic depression. Those who presented with depression but who were discharged with another neurotic diagnosis were also included. These people were followed for fifteen years. It was found that patients with endogenous depression had longer index admissions, and were readmitted sooner, but spent less time ill than patients in either of the neurosis groups. Personality

abnormality accounted for twenty percent of the variance in outcome in the neurotic groups and only two percent of the variance in the endogenous group. This indicates that neurotic and endogenous depression are two illnesses. The authors recommended that treatment, especially for neurotic depression, should focus on modifying personality abnormalities.

In a similar study, Duggan et al. (1990) followed eighty-nine patients diagnosed as depressed in 1965. These subjects were interviewed and given personality tests to see if abnormalities in personality result in poor long-term outcome in depression. Eighteen years later, the series was followed up and the predictive power of the original data was determined. High neuroticism scores were associated with poor overall outcome and chronicity.

Other Therapeutic Variables

A good therapeutic relationship is essential in order to contribute to positive client change. This is one of the most consistent empirical findings in the psychotherapy literature. Dies (1983, p. 37), in a review of seventeen group psychotherapy studies, concluded that "there is substantial support for the importance of a

positive therapist-client relationship" both in facilitating the presence of other therapeutic factors and in determining positive treatment gain. Likewise, Lieberman (1977), in his review of group therapy research, stated: "Underneath all the activities that fall into these two types (patient-therapist, patient-patient) lies the assumption that cure or change is based on the exploration and reworking of relationships in the group" (p.29). As a result of conducting a review of the process and outcome literature on individual psychotherapy, Goldfried et al. (1990) have come to a similar conclusion. They state that: "Research reviews have also shown that therapists account more for outcome variance than does type of treatment" (p.671).

Robinson, Berman, and Neimeyer (1990) in a quantitative review of the research on the efficacy of psychotherapy for depression, analyzed studies that compared psychotherapy with either no treatment or another form of treatment. Their article assessed (a) the overall effectiveness of psychotherapy for depressed clients, (b) its effectiveness relative to pharmacotherapy, and (c) the clinical significance of treatment outcomes. The studies selected for review investigated a variety of psychotherapeutic methods. These can be classified according to the following categories; (a) cognitive, (b)

behavioural, (c) cognitive-behavioural, and (d) general verbal therapy such as psychodynamic therapy, client-centred approaches or interpersonal therapy. The authors confirm that depressed clients benefit substantially from psychotherapy, with gains comparable to those observed with pharmacotherapy. Initial analysis suggested some differences in the efficacy of various types of treatment. Nevertheless, once the influence of investigator allegiance was removed, no evidence remained for the relative superiority of any one type of therapy.

Group Therapy

Robinson et al. (1990) conducted an analysis on the efficacy of group and individual therapy. They discovered that the two approaches were comparable and that both treatment formats produced more improvement than no treatment.

There is a paucity of research on group therapy and depression. One example is a study by Beutler et al. (1987). Subjects were fifty-six individuals, age sixty-five or older, who were diagnosed with major depression. The study was designed to explore the relative and combined effectiveness of alprazolam (Xanax) and group cognitive therapy. These individuals were

treated over a twenty-week period in one of four groups: (a) alprazolam, (b) placebo, (c) cognitive therapy plus placebo and (d) cognitive therapy plus alprazolam. The results revealed that individuals assigned to group cognitive therapy showed consistent improvement in subjective state and sleep efficiency relative to non-group therapy subjects. It is interesting to note that no differences between alprazolam and placebo were found, regardless of whether individuals received group cognitive therapy. Subjects assigned to group cognitive therapy were less likely than their counterparts to prematurely terminate treatment.

Conclusion

It is clear from the above reviews of outcome studies that psychotherapy is effective in the treatment of depression. The focus in recent depression research has been on comparisons among different types of therapy. The outcome studies reviewed call into question claims cited earlier in this paper, such as those by McLean and Hakstian (1979), that one treatment is superior to another. As a result of the failure of researchers to demonstrate the clear superiority of any treatment, we are left asking: what are the curative elements in the

treatments? As one researcher put the question: "What kinds of change are produced by what kinds of treatments, for what kinds of patients, by what kinds of therapists, and under what kinds of conditions? (A. E. Kazdin, 1983, p.266).

Throughout history, philosophers and clinicians have investigated various possibilities, such as character, temperament, and environment, in order to come to some understanding of why some people are vulnerable to depression. More recently, psychoanalysts have emphasized the role of loss and the turning inward of anger against the self, as sources of depression. Cognitive researchers have focused on the negative cognitive attitudes that depressed people hold about themselves. The social interaction theorists considered the interaction of the depressed person with his or her social environment to be the crucial factor in the development of depression. Life event theorists have claimed that stressful life events are risk factors in depression. The interpersonal theorists have postulated that undue interpersonal dependency is a major factor contributing to depression. Finally, with the advent of the psychopharmacological revolution, socio-biological theorists have argued that the sources of depression lie in the chemistry of the brain.

The research studies quoted above have investigated primarily single-cause theories. The present study, in taking a phenomenological hermeneutic approach, investigates women's experience of depression inclusively as opposed to reducing it to a single cause, single description, or single meaning. The experience of depression can have multiple meanings, multiple causes, and multiple descriptions, and to grasp the whole, the phenomenon in its entirety, by listening to the voice of women who are depressed, is to add a new perspective to the current medical and psychological understanding of female depression.

METHOD

Procedure

The purpose of this research was to investigate the lived experience of depression for women. Data were obtained from group psychotherapy sessions, conducted in the conference room at the Mental Health Centre in Victoria, B.C. The therapy consisted of weekly two-hour sessions over a period of twenty-four weeks, on Wednesday mornings from 11:00 a.m. to 1:00 p.m. from November 8, 1989 to May 2, 1990. The participants in this study were a group of seven women who were diagnosed as clinically depressed. Their age range was twenty-five to fifty-eight. One was married. Three were supported by social assistance; the others supported themselves by working. They were referred to me by their attending physicians.

I began this study with intake interviews, in which I explained the format and expectations of group therapy, and gave verbal assurance that participation was voluntary. In the opening group therapy session, I reiterated that participation was voluntary. In addition, I stated that the members of the group were free to withdraw at any time. I stressed the importance of

confidentiality and anonymity, discussed these principles in detail, and reassured group members that everything said in the sessions would be respected and treated in strict confidence. A written contract specifying the conditions of confidentiality was presented to the group. Each member signed this contract. The twenty-four sessions were recorded on audiotape, transcribed by the author onto typewritten manuscript, and the data analysed. Following the analysis of the data, I telephoned three of the participants in order to clarify meanings and statements extracted from the transcript.

Data Analysis

One very destructive way in which our society blocks flight into illness is to represent, diagnose and treat our modern psychopathologies in terms of the medical model, without regard for their symbolic and spiritual significance: without careful thought for the significance as historical manifestations of diseases in the Self's experience of Being, and of itself in relation to Being (Levin, 1987, p.482).

A conclusion I have drawn from my literature review is that statistical methods enable us to evaluate

epidemiological and demographic variables, while the qualitative method allows for the direct understanding of the personal experiences of those who suffer from depression. I investigated several types of qualitative data analysis, such as ethnography (Hoshmand, 1989; Spradley, 1979), case studies (Binswanger, 1958; C. E. Hill, J. A. Carter, & M. K. O'Farrell, 1983; O'Farrell, Hill, & Patton, 1986), the critical incident technique (Woolsey, 1986), and the phenomenological-hermeneutic (Van Manen, 1990; von Eckartsberg, 1986). In order to examine women's personal experience of depression and to gain an in-depth and meaningful understanding of this phenomena the approach that is best suited to my research is the phenomenological-hermeneutic one. Phenomenological research seeks to reveal and comprehend phenomena from the participants' perspective.

In order to understand the meaning of depression for each of the women in the group it was necessary to clarify my perception of the phenomenon under study. There is a technique called "bracketing", which requires the researcher to suspend, as much as possible, his or her biases. In the present study, bracketing was accomplished by my setting aside the meanings and interpretations of depression that I have acquired and entering into the world of the individual whom I am interviewing. Van Manen

(1990, p.47) claims that if we try to forget what we know about a phenomenon it will creep into our minds unexpectedly. Therefore, we must "make explicit our understandings, beliefs, biases, assumptions, presuppositions, and theories." I have accomplished this by reviewing the research and literature on depression and by documenting my personal experience of depression. I. Yalom (1980, p.25) states that, "the analyst must approach the patient phenomenologically; that is, he or she must enter the patient's experiential world and listen to the phenomena of that world without the presuppositions that distort understanding." However, Gadamer (1976) argues that we bring our presuppositions to any situation. These biases are a result of our cultural and personal background and experiences. He notes that this is only a problem if it is not taken into account.

Colaizzi (1978) and Van Manen (1990) emphasize the importance of personal experience in research. Van Manen (1990, p.53) notes that: "The lifeworld, the world of lived experience, is both the source and the object of phenomenological research." For Colaizzi, experience is:

- (a) objectively real for myself and others, (b) not an internal state but a mode of presence to the world, (c) a mode of world presence that is existentially significant, and (d) as existentially

significant, it is a legitimate and necessary content for understanding human psychology (p.52).

I am in accord with Colaizzi's view on phenomenological human research becoming "existential therapy" in the sense that this research attempts to investigate the person in context and to take into account her life situation. Colaizzi (1978, p.69) notes that:

Genuinely human research, into any phenomenon whatsoever, by seriously including the trusting dialogal approach, passes beyond research in its limited sense and occasions existential insight. This is nothing other than therapy.... It is clear that existential therapy should draw in the totality of the human person, e.g., his perceptions and cognitions, emotions and attitudes, history and predispositions, aspirations and experiences, and patterns, styles, and contents of behaviour.

My experience of depression has enabled me to empathize with others who are depressed. Through my own experience I have realized that being depressed affects not just depressed women but their families, friends and co-workers. My own experience of depression allowed me to enter the depressed women's world to a greater depth. It enabled me to speak their language and to read between the lines, hearing what they may be unable to verbalize.

Finally, having experienced depression and recovered, the women viewed me as credible. They knew I had been there and could provide hope that they too, would survive.

Leahey (1989, p.2) describes the clinical skills necessary for both collecting and analyzing the data in qualitative research:

Being able to listen and interview in depth, being able to summarize and to take the whole context into consideration during interpretation, being sensitive to implicit aspects of human expression, and finally, being able to create a research situation of mutual trust and understanding.

The approach that I chose for my study follows, with some modifications, that of Van Manen (1990), in Researching Lived Experience. In order to use the phenomenological-hermeneutic approach I must do the following: (a) turn to the phenomenon which seriously interests me and commits me to the world; (b) investigate experience as I live it rather than as I conceptualize it; (c) reflect on the essential themes which characterize the phenomenon; (d) describe the phenomenon through the art of writing and rewriting; (e) maintain a strong relation to the phenomenon; (f) balance the research context by considering parts and whole (Van Manen, 1990, p.30).

According to Van Manen (1990, p.4), "Phenomenology describes how one orients to lived experience; hermeneutics describes how one interprets the 'texts' of life." Phenomenology is the study of the life world as one experiences it. It aims for a deeper understanding of the nature or meaning of everyday experiences. Phenomenology is a research method for "mapping the qualitatively different ways in which people experience, conceptualize, perceive, and understand various aspects of, and phenomena in, the world around them" (Tesch, 1990, p.65). I like the manner in which Merleau-Ponty (1973) speaks of phenomenology as a poetizing project. He states that phenomenologists try to speak with the use of incantation, evocatively, as a "primal telling", using the voice in an "original singing of the world".

During the first half of this century, psychology's attempt to seek approval from the world of hard sciences created a schism between the clinical practice of psychology and the methodology of research. A phenomenological-hermeneutic orientation is more helpful in the act of practice, while quantitative methods have a place in thinking about or understanding psychology. In speaking of the traditional antithesis between psychological practice and research, Osborne (1990) says that: "Phenomenological research methodology has a close

affinity with counselling practice and stays close to the meaning of human experience" (p.79). The "process research" of Greenberg (1986) is an attempt to solve the difficult task of creating an appropriate methodology for studying counselling:

The emphasis upon verification rather than discovery which is characteristic of contemporary psychotherapy research seems to be a distortion of the actual emphases in the practice of true science (p.711).

The phenomenological-hermeneutic approach is particularly appropriate for exploring the meaning of women's experience of depression. Many books have appeared in recent years describing new theories of the cause of depression, and yet the descriptive aspects of depression in women have been neglected. Van Manen (1990) appears to have a rare understanding of the situation:

To understand what it means to be a woman in our present age is also to understand the pressures of the meaning structures which have come to restrict, widen, or question the nature and ground of womanhood. Phenomenological research is a search for the fullness of living, for the ways a woman possibly can experience the world as women, for what it is to be a woman (p.38).

The following authors apply van Manen's assertion in using a qualitative approach in the practice of research (Polkinghorne, 1991; Woods, 1998). Woods criticises women's health research for the reductionistic point of view that is so prevalent. Woods claims that what is needed is an "increased emphasis on women's first-person experiences, as embedded in the context of their lives, a rapprochement of subjective and objective methods, and the generation of theoretical frameworks to account for women's health" (p.226). Quantitative research methods have helped us to isolate some of the factors influencing women's health. Unfortunately, these methods have yielded little understanding about how such factors operate in women's lives. Woods recommends that "future research should focus on experiential, dynamic analysis of women's lives, including transitions to and from parenthood and employment" (p.229). I believe that we must investigate women's stories to discover how work, parenting, and relationships are sources of both stress and support.

Having described phenomenology, I will now discuss hermeneutics. Hoy (1978) stated that, "In the absence of Hermes, the modern age needs hermeneutics" (p. 1). Hermeneutics is the theory and practice of interpretation. It is concerned with giving words to human experience. Hermeneutics was essential in this study as a tool for

interpreting meaningfully the phenomenological information about depression. The thoughts, feelings, images and other sensory perceptions of lived experience needed to be explicated in language; hermeneutics is the tool for this interpretive process. In this study I have used the voice of the participants in order to pursue a deeper understanding of women's experience of depression.

Hermeneutic research further involves a form of partnership in which researcher and subject are bound together in a search for common understanding.

Hermeneutic understanding unfolds as a result of the dialogue between researcher and subjects. Gadamer (1976, p.xxi) stated:

The hermeneutical conversation begins when the interpreter genuinely opens himself to the text by listening to it and allowing it to assert its viewpoint.... Word and subject matter, language and reality, are inseparable, and the limits of our understanding coincide with the limits of our common language.

Hermeneutic research demands that the researcher "dialogue with the data" (Tesch, 1987) in order to discern what it means. The text is read thoroughly and each part of the text is considered in relationship to the whole. As each part becomes better understood, in association

with the whole, the text itself becomes more intelligible. With each new understanding of the text as a whole, the parts are interpreted yet again. This is known as the "hermeneutic circle."

Jardine and Grahame (1988, p.160) describe hermeneutic research as interpretive in another way, in that it is "embedded in the presuppositions of language, history and culture." Thus, another task of hermeneutic research is to place the text in a biographical context. This means that I had to take into account not only the depressed woman and her personal circumstances, but the larger social and historical situation, because all of these affect women on a psychological level. The self always exists in context (Kaschak, 1992). The transcripts of the current study were reflected upon in the light of the biographical context. Conducting research within a context of biography, history, and culture suits my philosophy of psychotherapy, because I believe that it is crucial to take my client's life situation into consideration in our work together.

In addition to history and culture, language is important in hermeneutic research. Language is the primary organizer of one's experience of the world. It gives voice to experience. It is part of thought and perception. Most of what we know about a person's

experience of depression is filtered through language. Tannen (1990) has researched the language used by women in everyday conversations and found that they are pervaded with statements about relationships and their connections with others. Language is the primary tool in psychotherapy: "For phenomenological-existential psychotherapy, psychotherapy is therefore essentially a language event and psychotherapy happens within the context of language, of speaking, listening and remaining silent" (Kvale, 1986, p.187).

Lived Experience

When one is directly confronted by the suffering of another human being, something in one's soul changes forever (Cottle, 1977, p.40).

The concept of lived experience is intrinsic to the phenomenological-hermeneutic method. The assumption is that the richest source of data is a person's self-knowledge. In this study I used exactly such data, in the form of conversations with women, as a means to explore the way in which women who are depressed experience the world. Husserl's dictum, "back to the things themselves," is an important starting point. Lived

experience is derived from Husserl's idea of lifeworld, which he described as "the 'world of immediate experience', 'the world as already there', 'pregiven', the world as experienced in the 'natural, primordial attitude', that of 'original natural life'" (Van Manen, 1990. p.182). Exploration of lived experience is a way to come to a deeper understanding of our world.

Taylor and Bogdan (1984, p.6) note that a "central theme in the phenomenological perspective is experiencing reality as others experience it. Qualitative researchers empathize and identify with the people they study in order to understand how they see things." Through phenomenological research, we search for the possible meaning structures of our lived experience and by so doing we come to a fuller grasp of what it means to be a human being. Merleau-Ponty (1962) claims that an individual is "condemned to meaning" (p.xix). In other words, people are constantly involved in interpreting and making sense of the situations in which they find themselves.

Leahey (1989, p.12) claims that there is a "natural inclination of people to tell stories in order to organize their thoughts, to understand their experiences and to construct meaning in their lives." I have used this natural inclination of people to tell stories as a rich source of data about how women experience depression.

In speaking of phenomenological research Polakow (1984) notes:

It is a weaving and spinning--the interlacing of the threads of our lives and the lives of others that constitute our phenomenological texts. It is here that our praxis finds its origins and creates the possibilities for a human literacy (p.12).

Polakow's quotation invites us to discover the essence of our experience and of the experience of others. As defined by Cayne (1988), essence is: "the most significant part of a thing's nature; the sum of the intrinsic properties without which a thing would cease to be what it is, and which are not affected by accidental modifications; the subject in which attributes adhere". A phenomenological perspective guides us back from theoretical abstractions to our lived experience. According to Dilthey: "The preferred method for human science involves description, interpretation, and self-reflective or critical analysis. We explain nature, but human life we must understand" (Van Manen, 1990, p. 4).

Personal Experience

In phenomenological research, the scientist begins with his or her own experience. Van Manen (1990) states: "The lifeworld, the world of lived experience, is both the source and the object of phenomenological research" (p.53). My own experience of depression is an essential tool in the study of the lived experience of depression and enables me to empathize with, and to grasp the essence of other women's experiences of depression. Phenomenological research is always a personal project. "We find in ourselves, and nowhere else, the unity and true meaning of phenomenology" (Merleau-Ponty, 1962, p.viii).

Etymological Sources

I have explored etymological sources to discover more about some of the words used to describe depression. Etymology offers a way to retrieve forgotten meanings, to discover how words were derived, and how they have developed: "Being attentive to the etymological origins of words may sometimes put us in touch with an original form of life where the terms still had living ties to the lived experiences from which they originally sprang" (Van

Manen, 1990, p.59). The search for origins of words will not impose meanings but rather give clues to uncovering meaning. Webster's Dictionary indicates that the term depression originates from the Latin, *deprimere* (de=down, *primere*=to press) or, to press down, to sink.

Idiomatic Phrases

I have analyzed colloquial language, everyday phrases and expressions because cultural belief systems are sometimes expressed in everyday idioms. People describe their experience of depression in a myriad of ways. Expressions like "cheer up", "I'm blue", or "I feel down" may yield unexpected insights.

The use of common psychiatric jargon frequently implies that giving something a name or changing a name represents new knowledge. Terms such as "chemical depression" indicate a medical frame of reference, and denies the personal experience and meaning of the individual. Such bias is reflected in the public understanding. What does labelling of this sort mean to the woman who is diagnosed with "chemical imbalance" or "chemical depression"? One of the implications is that she is ill or has a disease requiring medical intervention and medication. Another, more hopeful frame of reference

is to regard depression as a productive and temporary adjustment to a change in life situation. Such a frame of reference will assist the individual in taking responsibility for alleviation of symptoms.

Use of Metaphor

I have also investigated women's use of metaphor in describing their experience of depression. Aristotle defines metaphor as "giving the things a name that belongs to something else; the transference being either from genus to species, or from species to genus or from species to species or on the grounds of analogy" (Sledge, 1977, p.119). Metaphors are widely used in psychotherapy because of their ability to convey multiple meanings simultaneously and because they provide a means for expressing unconscious material which has been repressed (Barlow, Pollio, & Fine, 1979; Erickson, Rossi, & Rossi, 1976; Matthews & Langdell, 1989). Contemporary therapists such as Combs and Freedman (1990) advocate the use of metaphor in psychotherapy: "Metaphor, with its multidimensional and inexact nature, allows psychotherapy to be purposive while leaving room for 'the random'" (p.xviii). In his psychotherapeutic practice, Sledge (1977) uses metaphor to interpret and facilitate patients'

understanding of their experience. In discussing the therapeutic use of metaphor, Sledge claims that:

Interpretations are therapeutic to the extent that unconscious fantasies, conflicts, and mental expressions are identified, related to the reality context of the patient's present experience and behaviour, and presented in such a manner and time that the patient is able to hear the interpretation, integrate it, and work through the material.

Interpretations work to relieve repression, bring the unconscious into consciousness, provide insight, and ultimately to facilitate symptom relief (p.116).

Descriptions from Art, Literature, and Poetry

Characters in Existentialist literature, such as Antoine Roquentin (Sartre, 1964) and Meursault (Camus, 1974) gave me greater insight into the existential despair of depression. Some of the finest descriptions of the phenomenology of depression have appeared in literature. Robert Burton (Babb, 1965) wrote eloquently from the vantage point of a sufferer of depression in his text Anatomy of Melancholia, first published in 1652. In his discussion of Oedipus Rex, Freud (1953) claimed that: "Great literature survives because something in the reader

leaps out to embrace its truth" (p.263). We share a common truth with fictional characters. James (1902) wrote of his experience with depression: "The world now looks remote, strange, sinister, uncanny. Its color is gone, its breath is cold, there is no speculation in the eyes it glares with" (p.151). In describing art as a lived experience Van Manen (1990, p. 74) states: "Because artists are involved in giving shape to their lived experience, the products of art are, in a sense, lived experiences transformed into transcended configurations" (p.74). The imagery in art captures not only the beauty of creation but speaks directly to the heart. It is not just an intellectual exercise in form and patterns but an immersion in the emotions. The assumption behind using art and imagery therapeutically is that the linking of intellect and emotions in art touches their pain and helps them to heal.

I asked the women in the group to keep a daily journal in which they were to describe their experience of depression. I also encouraged them to write poetry, draw, paint, or create sculptures in order to depict their experience of being depressed.

Thematic Analysis

Thematic analysis refers to the process of recovering the theme or themes that are embodied and dramatized in the evolving meanings and imagery of the phenomenological data (Van Manen, 1990). Tesch (1987, p.7) claims that "The phenomenological researcher must bring into play the intuitive knowing that senses what is there. It grows out of a pre-reflective familiarity with the experience, and in this sense it is re-cognition." Such intuitive recognizing produces new insights. Van Manen (1984) describes phenomenological themes as if they were "knots in the webs of our experiences, around which lived experiences are spun, and are experienced as meaningful wholes" (p.59), rather than as conceptual formulations, or categorical statements.

I have analyzed the themes that emerge from the women's stories in the transcripts of group sessions. I used the selective reading approach (Van Manen, 1990) in order to isolate themes. Briefly, it requires reading the transcript several times and questioning which statements or phrases seem particularly essential or revealing. Such statements and phrases are then highlighted and annotated in the margins. Phrases, sentences, and expressions are highlighted. Themes are discarded and retrieved as deeper

insights and understandings occur. It is a practice in thoughtfulness and reflection; I returned to the material again and again to disclose new ways of seeing and understanding.

Writing and Rewriting

Phenomenological writing is an integral part of this research approach. It often has a poetic quality: "Poetizing is thinking on original experience and is thus speaking in a more primal sense" (Van Manen, 1990, p.13). As stated above, phenomenological researchers try to grasp, through language, the wholeness, the totality of the experience. Writing and rewriting is a necessary aspect of the phenomenological hermeneutic method. As part of the writing and rewriting, I used transcribed quotations from research subjects, in an attempt to achieve an "evocative telling" (Van Manen, 1990) of their experience. The following procedures were also employed: (a) discerning the themes; (b) analytically describing the experiences in ever-increasing depth; (c) giving examples; (d) incorporating and developing the analysis within existential themes such as temporality, spatiality, communality, and corporeality; and, (e) discussing ideas with a colleague who is also engaged in phenomenological

research. Writing and rewriting as emphasized by Van Manen (1990) is, I believe, an essential step in distilling the meaning of women's experience of depression in this study.

Conclusion

There is a need to conduct research that refines conceptualization and measurement of variables related to the biological, psychological, and social factors associated with women who are depressed.

The qualitative approach appears most appropriate to study women's experience of depression. I have yet to discover a single study of this nature in the professional literature; the current study is an attempt to remedy the situation.

FINDINGS AND DISCUSSION

Reflections on Transcribing the Tapes

As I reflected on my experiences with the group of seven women it impressed me that we had been on a journey of growth together. We had travelled the rough seas and uncharted territory of personal growth and discovered islands of wisdom. We had confronted undersea monsters such as repressed memories of sexual abuse and other trauma. Unexpected treasures of happy memories, forgotten talents, and strengths were unearthed.

Listening to the tapes I felt a closeness to the women, and an immediacy of the experience we shared in the sessions. We have each moved on in our lives and yet, through the tapes, I was once again privileged to be allowed to share their pain, hardships, sorrow, joy and laughter.

As a result of my experience conducting groups, I would agree with Carter (1977):

All-women groups are likely to be more effective than individual therapy or mixed-sex groups, because women then tend to become less dependent on one person and they learn to receive and give support and protection from and to other women.

In the opening session I heard the tension and anxiety in the women's voices as they introduced themselves and described why they were participating in the group. As the group became more cohesive, the atmosphere changed. Members were learning to trust, and we worked on deeper, more intense and painful issues. Close friendships developed among the women. This had a healing effect, allaying their feelings of loneliness, isolation, and their beliefs that they were "weird" or "insane". Some of the women learned how to confront negative behaviours in themselves and each other, and as a result they learned how to change self-destructive behaviours. On one occasion I had come prepared with a lesson and exercises on self-esteem. In the room I sensed an emotional climate of deep pain and loneliness, so I changed plans and worked on the pain. There were poignant moments when one woman's story touched all of us and brought us to tears. There were moments of laughter and excitement as well as those of silence, tension, anger, anxiety, and pain. Once a gentle, timid, woman described how her ex-husband continued to harrass her. Her experience of being victimized seemed to resonate with all of the women. They spoke, one after the other, of their fantasies of revenge. These fantasies became more and more outrageous and absurd as each of the women spoke

until we became helpless with laughter. The victimized woman was profoundly affected by the experience of having seven women listen intently to her and join her through their humour and affection. From that point she spoke with strength and confidence. I no longer had to strain to hear her as I had previously done.

Listening to my voice was the most difficult part of transcribing the tapes. At times I felt annoyed and impatient with myself for not seizing the therapeutic moment. I would think: "why didn't I say this? How could I have missed that?" On occasion I was delighted by my insight and wisdom.

Throughout the process of transcribing the tapes I was reminded of how deep and entrenched are the women's problems. At times their situations really did seem hopeless. What do you say to a woman with three young children, who is depressed, painfully lonely, and living in abject poverty?

Researcher's Experience of Depression

In accordance with the tenets of phenomenological research, I believe that the researcher should examine her own experience of her subject as part of her research. In the Introduction I described that I have personal, as well

as academic reasons, for my interest in the study of depression. The following is a brief sketch of my experience of depression:

I lose my appetite for food, sex and life. An expression comes to mind: "I am closed in on myself"--like a flower that closes up for the night. I find it hard to breathe, or to concentrate, or to talk. I want to be alone and yet I do not want to be alone. I feel tired but I cannot sleep. I feel lethargic and heavy, yet empty. Everything I say or do is an effort. I hurt. I don't even know where I hurt. I just hurt. I want to cry but I cannot, as though I have forgotten how. I feel sad. My heart feels heavy. It is difficult to see. It appears as though there is a grey filter over my eyes. I want to be at home yet I take little notice of my surroundings. I long for the pain to stop. I feel trapped and yet unable to find my way out. I experience depression as paradox.

In one sense, this study has been an exploration of self, encouraging self-reflection and review of experiences of depression at various times throughout my life. I have changed as a result of this research. I have meditated on my identity as a woman, a therapist, and a researcher. I have also reflected on the women in the

group. I asked myself questions such as: Why did they become depressed? What strengths did each of them possess to lead them out of depression? Finally, how might they empower themselves to buffer themselves against future depressions?

Profiles of the Women

The following brief descriptions of the women are intended to bring the subjects alive as individuals. In accordance with the principles of phenomenological research cited previously, depression in these women is to be understood by viewing them as whole persons, physically, emotionally, cognitively, and as family and community members. The descriptions are based on self-report or, when appropriate, on psychiatric reports. Because they attended almost all of the twenty-four sessions, Pat, Eureka, and Francisca have more comprehensive profiles than members who missed sessions. Caroline moved to another city after twelve sessions and Naomi left the group in order to return to school after twelve sessions. Lynne and Ariana tended to be less verbal than the other women and for this reason they may appear to be under-represented.

Pat

Pat is 58 years of age. She was born in Europe and was separated from her parents at age 10. She spent the next few years in a wartime concentration camp in Czechoslovakia, not knowing if her parents were alive and unable to communicate with any of her family. Two years later she was reunited with her parents, only to discover that her father was in the process of divorcing her mother and leaving the family. She married in her twenties and came to Canada to live, full of hope for a happy life. After the birth of her first son she unexpectedly succumbed to symptoms which fit the diagnosis of psychotic depression. She was misdiagnosed by the attending psychiatrist and was hospitalized and treated for schizophrenia. The antipsychotic medication exacerbated her depression and she was given between eighty and ninety ECT (electroconvulsive therapy) treatments to counteract the depression. As a result of her illness her husband divorced her and he was granted custody of their children. She went from being a wife and mother in a large, beautiful house to being on welfare and living in a room in her mother's apartment. She developed an addiction to alcohol, recovered, but is now addicted to Xanax (antidepressant drug). A few years ago she was diagnosed as manic depressive by her psychiatrist and treated with

lithium. Within four months her condition stabilized and she has felt "much, much better since!" She realized that she still needed to deal with the pain from her childhood and expressed to me her desire to see a therapist in the future to accomplish this.

She speaks English with a precision that one usually hears from people whose native tongue is not English. She tends to repeat sentences over and over in an attempt to get her point across. She is also given to lengthy silences. She has the wisdom that a life of pain and sorrow brings. When she spoke to the group, or on a rare occasion gave advice, each of us listened intently because of the authority and power in her ideas. Pat is warm and motherly, and also extremely anxious. This unusual combination gives her an endearing quality.

Eureka

According to Webster's Encyclopedic Dictionary, "eureka" is defined as "an expression of intense pleasure on thinking suddenly of the answer to some knotty problem." Archimedes is reported to have exclaimed "eureka!" when he stumbled on the principle of specific gravity as a way of measuring the purity of gold. Eureka's chosen name fits her like a glove. When she

would discover a new truth about life or herself she would crow with childlike delight and amazement. For example, she exclaimed: "I lost forty or fifty pounds after I left my husband and I said: 'wow! I'm looking okay here. Men like me.' This was a hell of an experience. They all seemed interested. That was a hell of a heady experience."

Eureka is an inquisitive woman of thirty. She is divorced and living with a man. Both Eureka and her boyfriend are alcoholic. At present she is doing volunteer work and writing short stories. She has a tough, hard edge about her that makes one think that she has seen a lot of violence and has been nurtured little.

She was sexually and physically abused by her boyfriend and his friends when she was an adolescent. Shortly after, she was hospitalized for a suicide attempt and spent the next year in a psychiatric ward. She has lived with a succession of alcoholic, abusive men and she wants to gain self-esteem so that she can learn to live on her own and enjoy it. She has a delightful manner of speaking in unusual metaphors, such as, "My soul is up for grabs." She uses a "looking glass" logic: "I recently found out about a friend of mine who has basically gone 'out of order' in her mind and unfortunately she is here in the Eric Martin [psychiatric hospital], and she's

really bad. I thought well, if she's insane, I must be too. Right?"

Ariana

Ariana is a twenty-five year old single mother and nurse. She is devoted to her children and enjoys her work. She has been anorexic and bulimic for the past twelve years. She was adopted by alcoholic parents. She suffered repeated sexual abuse from both uncle and babysitter between the years seven to twelve.

She is soft-spoken, shy, and lacking in self-confidence. She has an appealing "little girl" demeanor that evokes a nurturing response in others, as if to make up for a childhood she never knew. Ariana appears simple and straightforward, but is actually very complex in her thinking. This was evident in her ability to understand the painful issues she dealt with in her childhood and adolescence. In speaking of her struggle with bulimia she stated simply and concisely: "It's like all the emotion is on the plate." She has a number of physical ailments such as endometriosis, migraine headaches, and complications arising from bulimia, such as muscle loss.

Naomi

Naomi emanates warmth and charisma. She is bright and sensitive. She is a registered nurse who works part-time, and attends university full-time in the school of nursing. She intends to study law upon graduation. She is forty-seven years old, divorced, and has two children in their father's custody. Her reaction to the pain of her separation and divorce nine years ago was so extreme that it resulted in hospitalization and a diagnosis of bipolar disorder. It was during her hospitalization that her husband was granted interim custody of their children.

Her main interests are art, dance, choral singing, and tennis. Naomi is a truly independent, spirited woman, yet when she was depressed she appeared downcast, tentative and softspoken. She has an understanding of self and others that I admired. She was uncompromising, deft, insightful and empathic in responding to a member's story.

Caroline

Caroline is an enthusiastic and outgoing woman of twenty-seven years. Her parents were divorced when she

was nine years old. Due to her mother's depression, Caroline was forced to take over the job of caretaker for her mother and younger brother at this time. They lived on an isolated island. Lacking friends her age and older mentors, she was forced to rely on herself. She discovered that writing in a journal enabled her to understand her world. Her mother threatened suicide several times during the following years.

Caroline is married to a man who is much older than she. She was hospitalized after a manic episode and diagnosed with bipolar disorder.

Her personality is very forceful and charismatic. She has a questioning mind, like a little girl who might have missed the developmental stage in which children question the way the world is, and who is making up for it now. It seemed essential that she discover why she had the manic episode. She questioned: "I just really want to find out why it happened. Was it just out of the blue or what? Was it just a spell, something that climaxes and carried me off?" Caroline appeared quick to adapt to any crisis.

Lynne

Lynne worked as a nurse until she injured her back five years ago. Thirty-two years old, she is currently separating from her female partner and mourning the loss of her partner and partner's two children. Lynne was anxious to work on her problems with relationships, feelings of dependency, low self-confidence, phobias and loneliness. She also wished to explore career directions. Lynne is personable and caring. She has a great interest in the outdoors.

Lynne has known loneliness most of her life and even now has very few close friends. She expressed a need to put up a front for most people in order to conceal her depression. She describes herself as: "Not a whole person."

Francisca

Francisca is a thirty-one year old single mother with three children. When we met in our first interview, Francisca sat slumped over in the chair. Her appearance was unkempt and she did not make eye contact. She appeared to be very angry and asked me what difference I thought I could possibly make to her life. I explained to

her what we would do in the group and what expectations we would have of her. She softened as she told me about her life and her children, and I began to have the feeling that I had met someone of great worth. Francisca is raising her children on welfare, which she supplements with income from occasional gardening and housecleaning. Her husband left her a few months earlier with one day's notice. She subsequently became despondent and suicidal. Francisca is a strong, capable woman. She chose, against the advice of her physician, to cope with her problems without antidepressant or anxiolytic (antianxiety) medication.

She grew up on a secluded island and attended a school where there were only eight children. She describes her childhood as lonely. She was beaten and taunted by the other children. She had a close relationship with her father, an alcoholic. Francisca moved to Victoria with her father when she was thirteen to be near him while he was dying of cancer. Because her father was subsequently hospitalized, she was forced to live with a foster family. Her foster father raped her. Her biological father died shortly after she turned fourteen. She became heavily involved in drugs and alcohol. Eventually she married a man who was alcoholic and physically abusive.

Francisca is intelligent and articulate. She behaves in a self-possessed manner. She is erudite and speaks with a clarity and precision that belie her background. Francisca lives her life with integrity. She would contact Social Services immediately when she earned a few extra dollars gardening. There is something about Francisca that is profoundly unashamed. Perhaps the way she carried herself, or in her manner of speech. I believe that people who have that quality have known shame.

Phenomenological Themes

As described in the Method chapter, I have used Van Manen's techniques for analysing the transcript. In particular, I chose to use the selective reading approach in order to isolate themes. Following Van Manen's protocol, I read the transcript several times while keeping the following question in my mind: which statement(s) or phrase(s) seem particularly essential or revealing about the phenomenon or experience of depression (Van Manen, 1990)? I then highlighted these statements. With the tool of thematic analysis I explored the women's language to discover the repressed, denied or painful nature of their experiences.

In my readings of the transcript I discovered a number of themes in the women's language as indicated in Figure 1. As the women in the group told their stories, the repetition of certain themes, and the intensity of emotion surrounding these themes, led me to realize that such themes represented prominent issues in the women's lives. These themes I have labelled as follows: (a) living environment, (b) experience of time, (c) intimate relationships, (d) the body out of balance, (e) language, (f) medication, (g) symptoms, (h) distortions of thought, (i) telling the story, (j) from victim to survivor, and (k) coping strategies. The four fundamental existentials of relationality, temporality, spatiality and corporeality, as described by Van Manen (1990) and Merleau-Ponty (1962) correspond to the following themes: intimate relationships, experience of time, living environment, and the body out of balance.

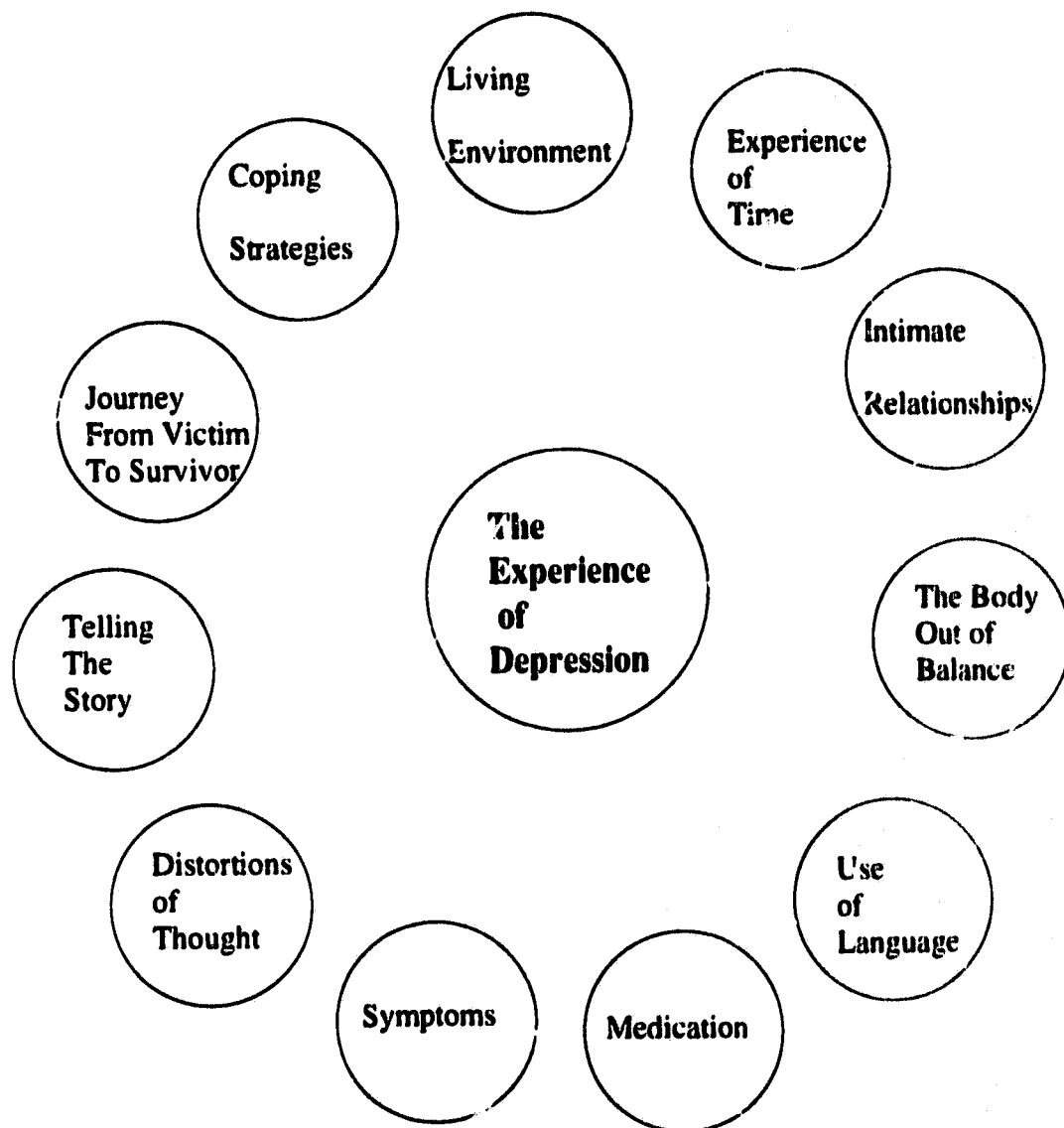


Figure 1: Phenomenological Themes.

Living Environment

Living environment was discussed in every session and was a topic of great interest to the women in the group. A woman's living environment has a significant effect on her affective state. Her home can be a refuge that is cozy, warm and comforting, or it can be a place of danger, hurt, and discomfort. The metaphor "feeling at home" is an indication of this need to feel good about our surroundings. Francisca gave birth to her daughter without the financial and emotional help of friends or family to support her at a crucial time in her life: "I was living in the front seat of my truck, you know? Climbing in to the garbage bin behind Safeway so I could eat, you know?" Francisca related this story to the group on three occasions. It was obvious that she still felt the pain and loneliness associated with that memory and that she needed to talk about it in order to expiate the pain.

Eureka lived in a psychiatric hospital for a year. She found that environment extremely unsuitable for her: "They wanted to keep me there till I was better but I thank Christ they didn't. It was the worst thing for me, to be kept in there. We moved here [to Victoria] and I immediately started to feel better." It is not clear what

specific aspects of the institution bothered her. It seems that she felt fettered rather than healed. Perhaps it was the staff's behaviour, or the presence of other patients. Perhaps it was the loss of freedom. Perhaps the physical environment of the hospital itself contributed to her depressed feeling.

Pat felt trapped in her environment in a different way. She had lived with her mother for the past nine years, and although she found it an oppressive living environment, she felt trapped by her sense of duty to her mother. Throughout the sessions she repeatedly described the dilemma: "I don't feel at home any more. I don't feel I live there. I go out and I am out most of the day. Sometimes I wish I could be home and just laze around."

Pat had had previous experiences of entrapment and homelessness:

I was eight and was sent away and at times I was alone and totally abandoned. I was in Czechoslovakia when the war ended and the borders were closed and here I was German and I had to wear identification and I went into a camp. It was not a refugee camp or a work camp. It was a concentration camp. There was nothing to eat. I survived on berries.

It is important to be able to control one's living environment. Francisca described a new freedom in her living environment as a result of her husband leaving:

They [the children] were not allowed to play with their toys in the house. He wanted them to play with a toy and put it away. He would not let them eat in the house except at the table. If they wanted a snack they had to sit at the table. I feel if they make a mess they can clean it up. No big deal. The kids started to bring their snacks into their room and I start to say no! And then I remembered he doesn't live here anymore and I make the rules now. It's a lot more relaxed. When he comes over and orders the kids to put their toys away I tell him that it's none of his business where they put their toys here. This is my house now! It's weird I never would have spoken like that before to him. I wouldn't have said anything. It was just so strange and felt so good.

Naomi's experience of her surroundings changed as her depression lifted:

I want to move. I live in a basement flat and it's dark and damp and cold and I hate it. It is depressing! I'm trying not to let it get to me but I know when I find a place above ground with lots of

light I'll feel so much better. I love plants and none will grow where I'm living.

It appears that she was able to exist in a depressing environment while depressed, but found it unacceptable as she became more hopeful about life. Like the tropism of plants, she grew towards the light.

Ariana has a different concern about her lived space. Because she suffers from bulimia, an eating disorder, and wishes to keep it a secret, Ariana finds it difficult to leave her home and spend time with friends: "Like this weekend I'm going out of town with friends in Vancouver and we're staying in an apartment there and I don't know how I'm going to do it because I can't eat with anyone."

The concerns relating to the theme of living environment have at least one thing in common: they all identify a need for control of one's living environment. When women are depressed, they often feel powerless to alter their living environment. I have noted that as the mood of a number of the women lifted during the course of the group, they gained the confidence to change their living environment to their liking. Naomi found a more cheerful apartment in which to live, Francisca purchased new furniture and rearranged her house, and Eureka made plans to leave her alcoholic boyfriend and move to a new

apartment. Caroline and her husband moved to a different city and bought a new house.

The theme of living environment can be compared with the existential theme of spatiality as defined by Merleau-Ponty (1962). He states that: "I am not in space and time, nor do I conceive space and time; I belong to them, my body combines with them and includes them" (p.140). The theme of spatiality is reflected in the importance of surroundings to the depressed woman. She needs a place of refuge where she feels comfortable and safe. Merleau-Ponty describes spatiality as an extension of the body. He gives an example of playing the piano, where the instrument is an extension of the pianist's hands. In another example he notes that "it is possible to know how to type without being able to say where the letters which make the words are to be found on the banks of keys." In like manner, the women in the group experienced their homes as an extension of their physical selves. If their home environments were depressing, they felt depressed. Four of the women in the group were unhappy with their living arrangements and managed to find more congenial surroundings. As their symptoms of depression alleviated, they found that it was vital for them to improve their living conditions.

Experience of Time

How long is this going to last? When am I going to start feeling better? These are the questions I am asked most frequently by women who are depressed, and yet the ones most difficult to answer. A depressed woman experiences distortion of the experience of time. Commonly, there is a perception that periods of time are lost, or that time is dragging by, or that hours or days are endless. Cognitive distortion of time involves thought patterns which influence memories of past events, evaluations of present circumstances, and expectations for the future. A depressed woman usually does not have access to a cognitive representation of a future without depression, as demonstrated by Eureka's frustration with her lack of hope for the future after fifteen years of depression:

I'll go along okay for a while and then I'll come crashing down and have a breakdown [depression] and it takes a lot of energy to come out of it, and then it happens again. I'm getting tired. Where does it end? When does it stop? That's what's getting me angry. I've been doing this for fifteen years. Breakdown, feeling good, breakdown, feeling good. When does it end?

Conversely, it is difficult for the depressed woman to remember how it felt to have good experiences in the past. Francisca's past is perceived through the grey filter of depression: "They've gone on for years [her depressions]. I can't say how often. It's more how often I don't feel depressed." The depressed woman is generally critical of herself in the present, especially of her ability to overcome depression itself, as is Lynne: "I feel like I've been going through this process for so long that I should've had it figured out by now."

The depressed woman finds certain times of the year more painful. Such anniversary reactions are experienced by depressed and undepressed alike. We may be caught off guard by unexpected emotion because we have repressed the conscious memory of an event that happened on a particular date a year ago or even many years ago. The unconscious memory of an event or unfinished grieving begins to surface.

Each of the women noted that Christmas was an especially painful time for her. Christmas was difficult for Pat because she was separated from her children and she found the winter months to be bleak and dreary:

I can say Christmas is the hardest time for me. I'm going through a very difficult time and I've been, I think it's when winter sets in and the rain and the

darkness affects me. November and December and Christmas.

Lynne joined in:

I don't want it [Christmas] to happen. I find it stressful at the best of times, everyone's getting gifts.... This year is especially hard, my first year away from my family. I really miss the kids and they miss me. I took some presents by last night and it was really hard. I cried and cried and my daughter cried too. It's really tough.

Caroline sympathized with Lynne. She was spending Christmas with her husband's family and she wanted to be with her mother and brother:

I've had the same feeling of just forgetting Christmas altogether. I don't want it this year. I just don't have the energy...I want to disappear and just go to the island and be with my own family until after Christmas. What I'll probably do is go for lots of walks to get away.

Naomi found Christmas to be a difficult time of the year because it revived painful memories of loss of family: "Christmas--I find Christmas a really stressful time ever since I split up with my husband. It's because of the kids and we've had really awful Christmases." Christmas is usually a time when families get together to

celebrate and the awareness of this heightens their feelings of loneliness and pain.

Most of the women were able to cite specific incidents that coincided with the time of onset of their depressions, despite the fact that their depressions had a duration of many years. Eureka attempted suicide and was hospitalized as an adolescent. She dates the onset of her depression as occurring at the time of her hospitalization, and she noted: "I've been doing this [depressed] for fifteen years." Pat traced the onset to the birth of her first son and claimed that: "This is the first time in twenty-three years that I'm beginning to come up [feel better]." Naomi describes the breakup of her marriage as the catalyst for her depression:

When I split up with my husband it was so incredible, so traumatic, so awful. It's nine years since it happened but at times it's like it's just fresh and it's really hard. At the time we were going through it, we were really awful to each other. I lost it [lost control] and I ended up going manic and spent three weeks in EMI [psychiatric hospital]. I'll never forget it. I woke up one morning in this foggy haze. You know I was so doped-up I could hardly see. Everything was so fuzzy. My lawyer came in to visit and I could barely see her. She gave me the news

that the custody hearing was held and interim custody was granted to my husband. God what's going on [crying]?

Francisca cannot remember a time in her life when she was not depressed:

I think it's been there all of my life. I remember in grade one being terrorized by the other kids after school, being tied to a tree and beaten and humiliated and thinking I was going to die there. I got beat up every day and I was too scared to tell anyone. I don't remember the early years too well [loss of long periods of time in childhood is usually an indication of trauma]. I just remember a lot of loneliness. Years and years and years and years.

Sometimes the events reported as associated with the onset of depression date from very early in life and thus are not subject to accurate recall. In other cases, the memory of the onset of depression is a distinct one. Further research is required to assess the relationship of precipitating events to diagnoses of depression.

The theme experience of time corresponds with the existential theme lived time or temporality. Time, according to Merleau-Ponty (1962), "is not part of the objective world. Past and future, in particular, 'withdraw' from being and can be found only as dimensions

of our own subjectivity. As such they appear in the field of our present." Van Manen (1990, p.104) defines lived time as "subjective time as opposed to clock time or objective time." One aspect of the depressed woman's experience of time is that her sense of time seems to change. Hours stretch endlessly before her; or, she is plagued by the realization that there is never enough time for her. She knows that she will never regain a lost childhood, yet must find hope in a future she cannot perceive.

Intimate Relationships

Each individual continually creates himself while he is interacting with others (Schaeffer, 1991, p.23).

The women were asked at the beginning of each group session to decide upon a topic as a focus for the discussion. They discussed their relationships and their concerns about the important people in their lives in every session. Other topics were also discussed, but relationships as a topic prevailed over all the others. The frequency of discussions about relationships in the transcript clearly indicates that this topic was the most extensively discussed.

Bowlby (1980) discovered how important intimate relationships are for a sense of well-being and for continuing healthy development: "In most forms of depressive disorder, including that of chronic mourning, the principle issue about which a person feels helpless is his ability to make and to maintain affectional relationships" (p.247). Because women in our culture strive for interpersonal connectedness, they are vulnerable to depression when they become isolated from others. Isolation faces them with the terrifying question of who they are, and what they are, outside of the context of a relationship. The research done by Gilligan (1982) led her to discover that while the developmental evolution for men is characterized by successive stages of separation and individuation, for women it is characterized by differing forms of connection and intimacy within relationships. A woman's sense of self is "embedded" in her important relationships, while a man experiences his sense of self primarily through separation from others and individualism. A woman tends to judge her worthiness in terms of her ability to care. Gilligan (1982) summarizes her point of view: "Women's place in man's life cycle has been that of nurturer, caretaker, and helpmate, the weaver of those networks of relationships on which she in turn relies" (p.17). As I read over the

transcript it quickly became apparent to me that the most pressing concern in each of the women's minds is her relationship with her family and friends. In fact, each of the women introduced herself in terms of her relationship with her family, original and marital.

Pat introduced herself by describing her neurotic, symbiotic relationship with her mother:

I live in an apartment with my mother and I have a very difficult relationship with her. I have two boys in their early twenties who live in Toronto....

I went to see a psychiatrist because I hated my mother so much and I thought how could I hate my mother so much when I lived with her?

On another occasion, Pat spoke in a slow voice, filled with despair: "I had an awful week. My mother is very depressed and I am very depressed."

While introducing herself, Lynne stated that she had recently "gone through a separation from a relationship." She goes on to say, "Now I'm really lonely. I haven't let go of that relationship. I think I'm obsessed. I can't seem to let go." On another occasion she stated, "I've been through so many crummy relationships that I now realize I'd rather be alone." Sontag (1972, p.127) stated: "The need to be solitary--along with bitterness

over one's loneliness--is characteristic of the melancholic."

In her introduction, Naomi also spoke of a broken relationship: "I'm divorced with two children who are in their father's custody and that's really hard for me." She separated from her husband nine years earlier and yet she still finds it difficult and painful to live apart from her children. Ariana has custody of her two young children and yet she has had a difficult time convincing her husband that she no longer wants to live with him: "I've been separated for a year or so and I've been harrassed by my husband since. He just won't accept it." Francisca's separation was also uppermost on her mind as she introduced herself:

I've recently come out of a pretty dramatic separation. My husband left me with three small children with one day's notice. I'm coming to the conclusion that I didn't deserve that [laughs]. I don't know how I'm going to cope financially or emotionally. I'm really depressed. It all feels pretty hopeless.

Eureka's situation is somewhat different from what is described in the other women's stories. She too, has recently separated from her husband, yet she appears preoccupied with her separation from her family of origin.

Several times throughout the sessions she voiced the concern that she felt as though she did not belong in her family:

I've been separated a year and three months. My main thing is I want to be independent. I have a problem with my family. I've never been a part of them for my entire life. My ex-husband, as far as I'm concerned, with the way my parents treat him, he fits far more into my family than I ever did. Anyways, I left him and he's sort of like family as well. I went through series after series of relationships looking for one thing or another. I'm in a relationship right now where I'm finding it partly okay and partly a lot of problems.

There is a recurring refrain of loneliness in the transcript. When Francisca stated that she "grew up with no friends," and had always been alone, it struck a familiar chord with several of the women. "When you talked about not having any friends. That was what it was like for me too," murmured Naomi. Pat commented that she would like to work on relationships and added: "I am very lonely.... I wish I had a male friend. I never had one. Sex always interfered. I think it would be so nice." Eureka responded: "When you said you hadn't had friends for years I know what you mean by that." Later she added:

"I haven't had a best friend since I was twelve."

Francisca remarked: "I've never had female friends."

After confronting her ex-husband with his abusive behaviour towards her and the children she sadly stated:

"It's real hard to say leave me alone when I don't want to be alone. I'm lonely!" On another occasion, Francisca said with chagrin:

I'm lonely! I don't really have any friends. I find it hard to walk into a room with people. I don't really know why. I've been a loner all my life.

I've been depressed all my life!

Eureka stated: "It's my second year alone and I hate it.... I have periods where I'm at peace with myself but there's always that menacing thing that's going to get me, so I never feel safe.... What if I am really all alone?"

In speaking of her recent experience with depression, Naomi softly uttered: "I was feeling really wrecked and totally alone." Each woman in the group described her experience of loneliness, unique to her, yet familiar to the others. One reason why groups are known to be therapeutic is that members are able to voice painful existential issues such as loneliness while receiving acceptance and validation of their experiences by the others. Pat stated that, "It is so wonderful to have a

support system. I could not do what I've done for myself these past weeks if I'd been alone."

The relational capacity of women can be used in a destructive manner: "When women try to fit their relational capacities and desires into the roles of 'wife' and 'good woman', they run the risk of adapting to the needs of those around them and becoming alienated from themselves" (Jack, 1991, p.44). Lynne found this to be true for her:

The three years I was in a relationship I just thought about what my partner and the kids needed and didn't give a thought to myself and now [after separation] I'm just more aware of what I want or am needing and there's just certain things in my life I've just put up with because I've just gone along with them, like my sister never having a babysitter because I was always there.

The benefits of separation from unhealthy relationships were being discovered by some of the other women as well.

Ariana said:

My son had his surgery. It was really scary and draining but it turned out well. I'm worn out now. I realized as a result of this that I like being a single parent. I can make my own decisions and I don't have to share the kids with anyone. I don't

have to keep them quiet because their father is in the house or he's tired or something.

Francisca voiced her agreement:

I like being a single mom too. I realized I don't have to make the damn bed if I don't want to. Nobody will say anything. You are your own boss. You don't have to rush home and cook dinner for your husband at six o'clock. You feed the kids when they're hungry. You have more freedom to make decisions for yourself.

Some of the women described a loss of self in their relationship to their spouses because they did not feel free to voice their thoughts and emotions; or, because they believed they had accommodated to their spouse's image of who they were rather than communicating and behaving in an authentic way. Jack (1991, p.29) states that, "As women describe the pervasive impact of depression, they most frequently call on the metaphor 'loss of self' to describe their inner experience." Jack describes "loss of self" as having three categories: First, loss of self is equated with loss of voice in the relationship; she is unable to speak what is on her mind and loses her authentic self because she believes she must defer to her partner. Second, she loses her self in attempting to fit into an image of how she ought to be, according to her partner and society. Third, she does not

speaking out in order to avoid conflict; because she has lost confidence in herself she fears being wrong. The loss of self described by Jack is apparent in the following statement of Lynne's:

My biggest problem is self-esteem and confidence and trying to get back into the work force. I had a back injury five years ago [working] as a nurse and actually I know what I should be doing I just can't get myself together to do it. I have anxiety attacks and I just came out of a relationship in July. I think about things and I just mull them over and over in my mind and it's really hard to let it go. That's basically it. It's really hard to let go. Now I have to find out who I am and what I'm going to do and doing it.

Francisca experienced loss of self because she was unable to voice her concerns to her husband:

Every time I see him I'm walking on eggs around him so that I don't get him upset or else he'll withhold child support...I've always been afraid to piss him off. I'm frightened he'll yell at me and I'll go to any lengths to keep him from getting angry. He can't talk to me without getting angry.

As a result of living on their own and discovering their strengths, some of the women in the group discovered

a new sense of "self". In the final group session, Francisca said with a great deal of pride: "I've gone from being a street kid living under a bridge in Saskatchewan to where I am now. A mother with three kids and a roof over my head." Ariana also discovered a new sense of self:

Two years ago D walked out on me and I had nothing. Since then I've been building and building and now I feel like my life is going okay. Now I'm really independent and I didn't realize how important that was for me until I got it. Now I'd never give it up.

Pat discovered a similar strength in herself:

I--I don't know if this is the right thing to say, but I always thought my whole happiness depended on my being with a man. I would think if only I knew a man I could go out with, for walks, or dancing. My ex-husband used to put me down so often; I was ground into the floor. One day I said to myself: "I don't need this crap. I don't need it. I can find my own happiness in myself. I don't need a man." After my divorce I went out with all these men and it was exciting and one day I said, "No, that's enough. Enough is enough. No more. I won't be put down again ever! Ever. Ever. Ever." But it's a long road.... over a period of years you reach a point and

say no more! That's it! And you have peace.

Suddenly I felt peaceful within myself. It was wonderful!...I found it was in myself.

There was a long silence in the room after Pat had spoken. A moment of thought extended into a silence that lasted for ten minutes. It was a living silence, waiting for words to catch up with feelings. The women were connected in their silence. As I looked around the room I became aware that all of the women were thinking about what Pat had learned through over fifty years of living. Gradually, they started to smile, then a few of the women laughed. Pat had unwittingly given each of us a gift, a new sense of self, a feeling of power. We had changed. Heilbrun (1988, p.130) claims that "Women, when they are old enough to have done with the business of being women, and can let loose their strength, must be the most powerful creatures in the world."

People who are depressed are strongly influenced by the social attitudes, mores, and behaviours which associate depression with illness. Knowing about negative social judgement, depressed women are often acutely aware of their effect on others. They try to hide any display of unhappiness for fear that it is socially unacceptable. Lynne felt that she needed to present a front to others:

I can't see people when I'm depressed because if I talk about some things--well, sometimes I feel despondent, not just sad. But I think it's also that you don't know how far to go or how far you should take it, and it's difficult. It's a pretty important thing to have someone to talk to. Sometimes you have experiences in life where you've trusted someone and they betrayed you...There's a lot of people out there that don't understand about this [depression].

Pat confided a similar betrayal:

I really don't have many people to talk to. I have to be careful who I talk to. I had a friend who kept asking me: "How are you? How are you?" So I tell her, "I'm okay now but I had a manic depressive episode." She was shocked and she said, "Oh, you had better go to a doctor." Then she was cold. That's why I like it here with you because I can talk openly.

Eureka agreed: "Right, as soon as they hear mental or emotional problem mentioned, they expect you to start salivating." Francisca added: "Fear of the unknown. Mental disease is contagious."

Parent role reversal is a symptom of a dysfunctional family in which the adults abdicate their role as parents and the children function as parents to the adults. In

her recent book, Banished Knowledge, A. Miller (1990) asks, "Is it permissible to bring a child into the world and ignore one's obligations?" She believes that parents must provide loving care for all a child's needs and if they are not willing to do this they must not have children. All of the women in the group spoke of incidents in their childhoods where parent role reversal was evident. Three of the women suffered the emotional abuse and manipulative ploy of a parent who continually threatened suicide. Two of the women were unable to confide in their emotionally distant, alcoholic parents about their sexual and physical abuse by an uncle, babysitter or caretaker.

Francisca described her father as alcoholic and her mother as "not overly [sic] motherly." Her childhood was painfully lonely and brutal and she had no one in whom to confide: "I got beat up every day [at school] and I was too scared to tell anyone." She added: "I don't remember the early years too well. I just remember a lot of loneliness. Years and years and years and years." Francisca is still attempting to get her mother to parent her: "Dammit mother, think about me for a change instead of just you!" Pat experienced abuse and neglect as a child in her parents' home and in the concentration camp she was sent to at eight years of age. She never knew

what it meant to be a child and to be loved and cared for. When she gave birth to her first child twenty-three years ago, she succumbed to a severe depression from which she is still recovering. As a result of this depression she was unable to adequately parent her two children. Pat is presently living with her mother and it was apparent from her statements throughout the sessions that she was parenting her mother. Pat stated sadly: "I could never identify with any childhood. Children play and laugh and I just stand there and watch and think--my God! Because I had the responsibility to look after myself." In describing her mother she said: "It makes me sad to see how depressed she is. I'm the care-giver definitely and sometimes it's a difficult role because I need to change." I asked Pat if her role with her mother was reversed. She replied: "Well now I'm the stronger one definitely. I am not the daughter. I am her mother! I have never thought of it this way before. I do know that, and I feel the stronger one in our relationship. Definitely!"

Ariana was not only responsible for parenting herself but for her brother as well:

Both my parents are alcoholics. I was left alone a lot and ended up raising my brother, parenting him instead of my parents doing their job. I'm really angry. Both my parents are self-centered.

Incredibly! They don't ever think about another person. They didn't want to be parents. Now that we're on our own they're kind of relieved.

Ariana was unable to go to her parents for protection and to inform them that she was being sexually abused: "I was sexually abused by a babysitter, my parents friends' son, so I could never tell anyone. Also by my uncle."

Ariana's father emotionally controlled her by threatening to die if she did not behave as he wanted her to:

He used to say anytime I made him angry, "You're the cause of this. I'm going to have a heart attack and die its your fault." I moved out when I was sixteen because every few days he'd say I was killing him and I couldn't live with the guilt.

Caroline's experience was similar:

I know how hard that is. When I was a little girl my mother threatened to go off the deep end because she was under stress and a single mom and stuff. But the threat of suicide--that's hers! Those are her problems!

Until people are educated about its harmful effects, parent role reversal continues through the generations. When Francisca's husband left, she turned to her daughter for help:

After my husband left I felt so alone, so overwhelmed by everything! I could not even get it together to change the baby's diapers. I was just overwhelmed. I'm really lucky to have a ten year old because she just took over. Which is amazing. She took over completely. She fed the kids. She put the baby to bed. She did everything! She even made me a cup of tea. I was really lucky.

During another session, Francisca related her concern for her daughter. It is apparent that the excessive expectations have taken their toll on this young girl:

I've been worried about N. She's been having terrible migraines. She doesn't tell me about them so I don't find out until she's vomiting that she's got one. She is a child who swallows her emotions. She's had to for so long to please daddy--to come across as a good, bubbly, quiet kid.

It is impossible for a woman to be in a relationship in a healthy way if she is unable to be authentic in her self. She must be free to state her thoughts and feelings rather than present a "false self" as described by A. Miller (1981) in her book, The Drama of the Gifted Child.

The theme of intimate relationships is analogous to the existential theme lived other as developed by Merleau-Ponty (1962) or relationality as described by Van

Manen (1990). Van Manen defines relationality as "the lived relation we maintain with others in the interpersonal space that we share with them." The theme of relationality is evident in the depressed woman's concern, as described above, about the effect of her depressed mood on others.

The Body Out of Balance

Depression has affected the women in the group in a variety of physical ways. When a woman is depressed it is often evident in her appearance. She stops looking after herself and appears unkempt. She may be either lethargic or agitated. She often appears slow in movement, thinking, and speech. Pat described some of the physical effects: "When I walk my legs feel real heavy...Everything is an effort. I'm not sleeping. Also, I'm so constipated. I'm not suicidal, just blah." She may lose her appetite and normal enjoyment in eating, perhaps leading to a significant loss in weight. She may overeat, filling up with food to relieve her sense of emptiness.

A good example of a woman who experiences physical symptoms related to depression is Stacy, the protagonist in the novel The Fire Dwellers, by Margaret Laurence.

As Stacy talks to herself (Laurence, 1969, pp.4-5) we discover how she perceives herself and what she thinks others expect of her:

--Everything would be all right if only I was better educated. I mean, if I were. Or if I were beautiful. Okay, that's asking too much. Let's say if I took off ten or so pounds. Listen Stacy, at thirty-nine, after four kids, you can't expect to look like a sylph. Maybe not, but for hips like mine there's no excuse. I wish I lived in some country where broad-beamed women were fashionable.

Everything will be all right when the kids are older. I'll be more free. Free for what? What in hell is the matter with you anyway? Everything is all right. Everything is all right. Come on, fat slob, get up off your ass and get going. There's a sale on downtown, remember?

McGrath, Keita, Strickland, and Russo (1990) analysed numerous studies and found a relationship between depression and eating disorders such as anorexia nervosa and bulimia. It is not known if there is a correlation or causal relationship between depression and eating disorders. At the time of our group sessions Ariana had been suffering from bulimia for twelve years. She stated: "My bulimia is out of control again. I'm having a hard

time with it. I can't sit down and eat breakfast or lunch or dinner with anyone, not even my kids." She claimed that the last time she was able to eat with others was when she was fourteen years of age:

I never ate with my family growing up. I always ate watching TV by myself so it was easy to hide back then. I still can't sit down with my family at a meal. I go over after everyone's eaten. It's like all the emotion is on the plate.... My parents were both alcoholics.

Three of the women in the group were diagnosed with bipolar disorder. People with bipolar disorder may experience feelings of elation or may feel only despair. Some swing from one extreme to the other. The common feeling they all describe is the lack of control.

While in a hypomanic state Caroline described how she experienced it: "A manic state for me, it's like a speeded up state and I rush around in more several directions than I can handle at once, and so have my passions and things I might say are disjointed [sic]." Her manner of speech at the time emphasized that she was in a manic state. Her mind was racing and it was difficult for her to get her thoughts across to others. Hypomania is defined as a mild degree of mania. The elated mood leads to faulty judgment, behaviour lacks the

usual social restraints, and the sexual drive is increased. Speech is rapid, animated, and confused; the individual tends to be energetic and easily irritated. The abnormality is not so great as in mania and the patient may appear normal but a bit more animated than usual (Oxford University Press, 1987). On another occasion, Caroline described her experience of a manic episode:

Very happy. Overly happy and I wasn't sleeping right. I was sleeping maybe two hours a night. Maybe three and it just progressively got worse and worse. It was a really up experience for me. I was just right up there having a good time, just being super busy around the house. In retrospect, it was bizarre behaviour.

Caroline's experience is a good example of the inability of those with bipolar disorder to predict or control or even acknowledge the manic episode:

For me the manic experience was wonderful. Maybe that was because I had a really supportive environment. I'm not afraid of it happening again. Also, I think I could tell by the symptoms what was happening, if I was heading in that direction.

Two months after stating this, Caroline demonstrated how false was her sense of control, because she attended the

group in a hypomanic state without any sense of control or awareness of her condition.

Naomi experienced manic depression as:

...powerful, really powerful. I was out of control, not eating, not sleeping, the whole thing...and then about three or four months after that I felt really depressed. So it's like it swings one way then the other.

Unlike the previous two examples, Pat's experience of bipolar disorder did not include a manic swing:

I'm a manic depressive too. I don't go this way [pointing up] I go that way [pointing down] and I go so far down I don't want to live anymore. I've been down so many times because I've been misdiagnosed for nineteen years and I've been down there so often I will never go off lithium...Before that I was treated as a schizophrenic. I was on antipsychotic medication which made me worse. And massive amounts of shock treatments. I must have had seventy or eighty shock treatments all in all. I would be worse when I came out of the hospital than when I went in, so that's why I wouldn't go off lithium. Never. It took about four months to adjust to lithium, but when I did, I became calmer and more peaceful inside.

Some of the women's physical symptoms are best grouped according to the diagnostic category of agitated depression as described by Lehmann (1985, p.793): "In agitated depressions, the anxiety component is dominant and spurs the patient to repetitive, aimless restlessness manifested in endless pacing, handwringing and moaning." Pat described such symptoms:

Sometimes I have an agitated depression in which I'm really being down but having a lot of energy and not knowing where to put that energy. Sometimes it comes out in anger. Other times it comes out in despair [wrings her hands constantly]...There were two times I became psychotic and I don't ever want to go through that again and I'm trying to hold myself together.

Lynne's experience was similar:

I can't relax. Sometimes I'm just going, going, going. I'm just continually on the go. I can't relax, and if I do, I get more depressed. I have to keep busy. It's almost like you're on a treadmill [her leg is constantly shaking]...I could not get a grip on myself.

Nodding in agreement, Pat said: "I have experience in this too. That is why it is so difficult for me to just sit quietly, and think quietly. It is always just

like someone is pushing me and pushing me." Eureka also experienced agitated depression: "I have depressions too. My idea of depression is someone who sinks down into it okay, but when I get depressed I go extremely hyper.... The thing that I can't control is panic. I tell myself to calm down, calm down."

It has been recently discovered that depression is associated with profound disturbances in the normal functioning of the immune system. It is believed that depressive illnesses are associated with an increased risk of infection, cancer and autoimmune diseases. In depression, the body's normal defences, such as white blood cells, cease to function efficiently. It has been well established that people have a high risk of dying in the first six months after the death of a spouse, and that the risk is particularly high for men (A. C. Carr, 1985).

All of the women in the group were suffering from physical illnesses. Lynne stated:

I'm having a lot of headaches and had a severe one last night. I've been sick and depressed. On antibiotics and antidepressants...I'm so sick of being sick. I feel heavy, paralyzed, irritable, panicky and helpless.

On another occasion she claimed: "My lower back is in a great deal of pain. I'm aching, and in constant pain, and it's really getting me down."

Ariana had a number of physical problems: "I'm seeing two doctors. One says there is nothing wrong with me and I don't have any reason to be bleeding like that. She also said I looked depressed. I feel awful. I feel numb." In the next session Ariana reported still more physical illnesses. "I've got a kidney infection so I'm on antibiotics and my blood pressure is normal but I'm still getting headaches. I'm bleeding again."

Francisca noted: "I've had PID [pelvic inflammatory disease] for the past two years and I need to go in for intravenous antibiotics once or twice a year. He [physician] says I'll eventually need a hysterectomy."

Secondary gain also deserves consideration in illness in depressed women. The concept of secondary gain originated in psychoanalytic theory and refers to the notion that people experience certain positive aspects in illness. Some common forms of secondary gain include monetary compensation, increased attention or sympathy, and the satisfaction of dependency needs. Secondary gains may further reinforce the patient's disorder and contribute to its persistence. Caroline repeatedly described her manic episode as a positive experience and I

asked her if it was not also frightening: "No, not at all. My doctor kept looking for anxiety and no problem. I felt fine. Everyone was looking after me."

The theme of the body out of balance has a relationship to the existential theme of corporeality (Merleau-Ponty, 1962). Van Manen (1990) states that lived body refers to "the phenomenological fact that we are always bodily in the world" (p.103). In describing the theme of the body out of balance, one could state that the depressed woman feels ill, not just with the psychological pain of depression, but with somatic complaints as well.

Language

There are specific forms of language that women use to describe their experiences of depression. For example, the specific language used in the transcript indicates that some of the women defined themselves by their diagnosis. Barrell (1987, p.425) points out the difference between the act of labelling and the object or experience of being labelled: "Language is a referral system. It is a great mistake to confuse a label with what is being labelled." Naomi, like many of the group, seems to confuse her diagnosis with her identity. In introducing herself to the group she announced: "I'm a

registered nurse. I'm a manic depressive. I have a really hard time with the fact that I'm a manic depressive. I hate it! I feel like it really influences my life a lot." The phrase: "I'm a manic depressive, as opposed to: "I have been diagnosed with manic depressive illness", or: "I have manic depressive illness" suggests that she has defined herself by her diagnosis. This conclusion is reinforced by her emphasis on manic depression as a fact, rather than a diagnosis, which is at best an educated, informed opinion which fits the facts. Morris and Morris (1985, p.171) define diagnosis: "A diagnosis of an illness is the identifying of the nature of the disease through examination of the patient. It is the illness which is diagnosed, not the patient."

It is interesting to compare Naomi's views with those of Pat, for Pat's diagnosis caused her years of grief. She introduced herself in the opening session:

I became ill shortly after my first son was born. I was misdiagnosed for nineteen years and treated as a schizophrenic. I was on antipsychotic medication which made me feel terrible, really sick. I was given massive amounts of shock treatment. Then someone diagnosed me as a manic depressive. It took me four months to adjust to lithium and I have been much, much better since.

Caroline's language indicates that she does not define herself by labelling herself as manic depressive, but rather separates the label from her person: "I was diagnosed with bipolar disorder. For me, the manic episode was a really positive experience."

Ariana's language indicates that she in some way personifies her diagnosis of bulimia, giving the impression that she is helpless as it runs rampant in her life: "My bulimia is out of control again. I'm having a hard time with it. I can't sit down and eat breakfast, or lunch, or dinner, with anyone. Not even my kids." Ariana was unable to eat meals with her family after the age of eight because she experienced intense anxiety in the atmosphere created by her alcoholic parents at the table. Mealtime is usually a time for family members to talk to each other, a time to be close to each other. Ariana was deprived of this as a child. Her experience of "my bulimia" continues to keep her from eating with her family as an adult.

Mental health professionals from Freud to the present have described depressed women by using derogatory words such as dependent, helpless, and passive. Such adjectives are insulting because they imply character flaws instead of describing symptoms exhibited by women in specific distress. Rather than taking responsibility for the

social and psychological reasons for depression, professionals who engage in such labelling essentially blame the victim. Labelling women "depressives" is denigrating because such a label defines women by their illness instead of treating them with dignity. Depressed women can become diminished by the meanings associated with the label in society's eyes as well as their own:

For we have the experience of ourselves, of that consciousness which we are, and it is on the basis of this experience that all linguistic connotations are assessed, and precisely through it that language comes to have any meaning at all for us
(Merleau-Ponty, 1962, p.xv).

The women in the group often described their experiences of depression metaphorically. I found their metaphoric language to be free of psychiatric jargon, and it enabled me to understand their experience on many levels. Matthews and Langdell (1989, p. 242) claim that, "In psychoanalysis, the therapist uses the metaphor presented by the client as an entry to the real meaning in the client's life." I found that the women's use of metaphor vividly expressed the deeper meanings that they were struggling to convey, as the following examples illustrate.

Eureka has a delightful manner of speaking in unusual metaphors. She used the metaphor, "My soul is up for grabs" to describe her experience of anxiety. Her metaphor for expressing her need to cry, yet feeling unable to do so, was: "It's like a dam and I'm bursting."

Lynne's metaphor, "cyclone of paranoia" is a graphic description of her experience, mentally and physically, when she has paranoid thoughts, as though she gets uprooted by the velocity of her paranoid thoughts and is unable to stop them.

Interestingly, Eureka also used this somewhat unusual metaphor to describe the despair and loneliness she felt when she attempted suicide. Cyclone of paranoia is an apt description of the actual felt experience of paranoia in the body and mind of these women.

Pat stated in a despondent tone: "Depression is what I call the bottomless pit of despair." Her pain and sense of hopelessness that her depression will end is evident.

Naomi's use of the metaphor: "It felt like the bottom has dropped out," suggests the intensity of her feelings of lack of control and lack of the support of the ground to stand upon. This metaphor accurately represents how she physically experiences the feelings of depression.

The despair is evident in Eureka's metaphor: "I'm not going to get better. There's not a light at the end of the tunnel."

Ariana, a member of the group who suffers from bulimia, described why she felt she could not eat with her parents: "It's like all the emotion is on the plate." For Ariana, food and eating represents emotional pain, so it is not surprising that she finds it difficult to swallow food that is imbued with negative feelings.

Francisca's fear of her abusive ex-husband is evident in her metaphor: "Every time I see him, I'm walking on eggs around him so that I don't get him upset." She had a restraining order to keep him off her property and yet she still could not voice her true feelings to him or he would withhold child support from her.

The women's metaphors evoked rich images that reveal an uncommon wisdom about psychological life. Phenomenological philosophers have a tradition of using metaphor (Heidegger, 1947; Merleau-Ponty, 1968; Ricoeur, 1967). These and other philosophers make use of metaphor in their attempt to capture the depth of human experience. Murray notes that psychology is slowly "beginning to suspect the metaphor for what it truly is: a powerful vehicle for the illumination of human living and an even

more powerful strategy for the articulation of human problems and life solutions" (Murray, 1975, p.284).

Medication

Six of the seven women in the group were on medication prescribed to control their depression. Much group discussion focused on the benefits derived as well as the problems resulting from the medication they were taking, as the following quotations indicate. Pat outlined her history of depression:

I was on antipsychotic medication which made me feel terrible, really sick. I was given massive amounts of shock treatment. Then someone diagnosed me as a manic depressive. It took me four months to adjust to lithium and I have been much, much better since. She goes on to describe her experience with psychotropic medication:

I haven't had a good week because I've been coming off my medication [Xanax]. I've been strung out most of the time and haven't been able to sleep all week. I haven't been paranoid for a long time and now I'm paranoid again and that scares me. Sometimes I think to hell with it I'm just going to go back on it again. It takes a lot of will power to say no but I

know if I don't do it now I never will do it. I've been on it for such a long time that my body says where is it if I don't take it.

Eureka suggested: "Why not wait until you're feeling better and your life is in order?" Pat responded: "There is never a good time. I just keep taking a larger and larger dosage. I make up my mind to do it this time and when I make up my mind I do it. I need to learn how to deal with it [depression]." Xanax is an anxiolytic and sedative. It is prescribed for people suffering from mixed anxiety/depression. Xanax is an addictive medication causing psychological and physiological dependence (Davis, 1985).

Eureka is cross-addicted to psychotropic drugs and alcohol:

I don't know about pills. I feel like I'm addicted to them now. Anything that happens, any little thing, I feel like I have to take a pill. Pills, pills, pills, booze, booze, booze. It's really depressing. It's a vicious circle...I was up till five the other night. The next night I took four tranquillizers and three sleeping pills and I was still awake till two-thirty in the morning.

Caroline had been taking lithium to control her manic episodes: "I'm on cruise. I've been levelled out by the

medication and I feel there is very little emotion in my life right now." Caroline was intent on learning about her diagnosis of bipolar disorder. She was adamant that she would learn control in order to avoid recurrence of the symptoms. Her main goal was to get off her medication [lithium] as soon as possible:

The doctor that I have deals strictly from a pathological, here take the drugs, we'll level you out. I don't have time to talk--and he's a good doctor, and he's got me to this point but I need to have more...The thing is I'm coming off the lithium and I think that's part of the reason I am able to grieve because lithium puts you on this level altitude space where you don't feel anything.

Pat also felt that her emotions were being suppressed: "I'm not just on lithium, but on antidepressants and anti-anxiety, so no wonder I can't cry. Everything is trying to hold my feelings in."

Francisca succeeded in overcoming depression without medication: "I talked to my doctor yesterday. He says I'm much improved. He says he's proud of me and I've been able to do it without antidepressants."

As a result of listening to what the women said about their experience with antidepressants or anxiolytic medication, I became convinced that while medication

sometimes is very effective on a short term basis, it is not a cure. The women's statements confirmed my belief that, rather than ameliorate their depression, medication suppresses their symptoms and prolongs the depression. Unfortunately, physicians have only a limited amount of time to spend with their patients and for this reason they often prescribe medication to help women cope with their painful feelings of depression. Women's inner voice can be too easily disregarded when women are given medication as the only solution to symptoms of depression. I believe that medication is necessary for some people, in order to enable them to cope with the intense pain and crippling disability of depression. However, medication must be combined with psychotherapy for long-term improvement (E. Frank & D. J. Kupfer, 1987; Weissmann, Jarrett, & Rush, 1987). Women need psychotherapy for their voices and dreams to be heard, and to be supported in making crucial life changes, such as leaving an abusive relationship or changing a career.

Symptoms

Depression is a complicated multifaceted disorder, involving a broad spectrum of feelings, moods, and behaviours. Women's experience of depression is

idiosyncratic and affects them in a variety of ways. The women's phrases aptly describe their physical symptoms of depression. Ariana succinctly stated, "I feel awful. I feel numb."

Francisca noted that:

When I'm depressed everything feels grey and I feel numb. My arms and legs feel too heavy to move. I can see the kids but I can't hear them or move. My mind is saying this is stupid why won't my body move? But it's too much effort.

The inability to move was mentioned by several of the women. Naomi stated: "I find if I'm really depressed I can't call anyone. I'm immobilized."

Lynne's experience was similar: "I feel heavy, paralyzed, irritable, panicky and helpless."

Pat described the somatic aspect of depression in a similar manner: "When I walk my legs feel real heavy. I didn't even want to come here. Everything is an effort. At home everything is an effort."

For three of the women the predominant symptom of depression was anxiety. Eureka said:

My idea of depression is someone who sinks down into it okay, but when I get depressed I go extremely hyper. I feel scatterbrained, confused, mixed-up. I have anxiety attacks. One of my favourite ways of

putting it, when I feel like that, is "my soul is up for grabs" that anybody could do anything to me and I can't fight back.

As previously mentioned, Pat suffered from agitated depression. She constantly wrung her hands as she described her experience of depression:

Sometimes I have an agitated depression in which I'm really being down but having a lot of energy and not knowing where to put that energy. Sometimes it comes out in anger. Other times it comes out in despair. I became depressed last month and it was such a terrible state. I didn't want to live and I felt so ill and of course with it the anxiety, the terrible anxiety.

Lynne is another who experienced agitated depression. While she described her experience her legs shook violently:

I can't relax. Sometimes I'm just going, going, going. I'm just continually on the go. I can't relax and if I do, I get more depressed. I have to keep busy. It's almost like you're on a treadmill. As soon as I sit down my mind starts going and I'm gone and I have to get up and do something.

Lynne's description of her experience with agitated depression struck a familiar chord for Pat, who excitedly echoed:

It's like someone is behind you all the time saying, "Go! Go! Go! Do it! Do!" I have experience with this too. That is why it is so difficult for me to just sit quietly and think quietly. It is always, just like someone is pushing me and pushing me.

The women also described the emotional symptoms associated with depression. Naomi, speaking slowly and barely audibly, said:

I've been just lying depressed and just waiting for something. I've been feeling paranoid and in the last few days it has just felt like the bottom has dropped out. I mean I've been able to carry on doing things--it's just there's this underlying feeling of sadness.

Lynne identified a similar experience:

I'm kind of in limbo. Last week I was really depressed. I was down. When I got up in the morning I couldn't cope. I didn't have any energy. My mind was paranoid. I was thinking up things in my mind and I didn't even know if they were true. But they were true in my mind. They had happened and I didn't know for sure if they had happened. I wasn't able to

cope with anything else I had to do. I was caught in the cyclone of paranoia and it was just too much.

Pat flatly stated that, "Depression is what I call the bottomless pit of despair." She continued:

I really feel it, the pain. I really feel the anger, the hurt, and the pain all over again. It's like it's coming through me all over again. I have will power and I know that. It's just that sometimes I feel very, very scared. Sometimes my mind starts to take over and I can't rationalize.

The experience of anger had also been true for Naomi: The anger isn't there the way it was. It's awful, it's wearing. It wears me out being irritable all the time. You know, being angry a lot all the time. I just get home, I'm exhausted, and it doesn't go away. I feel really angry and frustrated.

Eureka described a recent depression as a nervous breakdown and depicted her feelings of terror:

It was hell. I might as well have been floating around in a room. It was very messy, very frightening! Very threatening! Menacing! Like there were wolves out to get me and I couldn't fend them off all the time.

Ariana questioned the confusing feelings that she experienced with depression:

Everything I feel there's always another feeling attached; it's not like you can just feel one thing. There has to be ten emotions in there with them and so I feel one thing and then I feel overloaded and it snowballs, so then I'm down on myself.

A common perception of the depressed woman is that of someone who cries a great deal. My clinical experience with depressed women is that most of them do not cry. In fact they feel unable to cry, which in my opinion serves to perpetuate the depressed affect. Kristal (1982) defines affect as "Any feeling or emotion temporarily attached to an idea." Only one of the seven women in the group was able to cry and she had a difficult time controlling her tears. Eureka stated: "For myself I find it extremely hard to cry...I find it really hard to let myself cry. I don't know why; maybe I think it's a weakness." Ariana agreed: "I know I went a long time without crying and it has taken me a long time to cry again." Pat was also unable to cry, as she told me when I asked:

No. I don't cry. I don't know how to bring it on. It's been held down for such a long time. It's me. I don't seem to be able to pick myself up.... Really, it has been years since I could cry. It's because I'm in control of myself. It's not controlling me.

I'm controlling it. I worked so hard to have this control.

As Pat spoke about not being able to cry, tears actually began to flow down her cheeks and she stated incredulously: "This is the first time I've able to cry about this!" It was a dramatic moment, and the group was silent in empathy with Pat. Naomi responded to Pat's experience: "I can go for a long period of time where I feel a need to cry and I can't... For me it's like Pat said--I'm afraid of losing control." She later added that, "I've spent the past week crying and feeling really sad, but it actually feels okay. In fact, even though I'm feeling sad, it's coming from deep inside and it really needs to get out." I asked if anyone else needed to cry, but could not do so. Eureka answered: "Yes! I feel ashamed when I cry so now I can't... When I want to cry it's like I'm really tense and uptight and I want to let it out. It's like a dam and I'm bursting." Caroline found that it was also difficult for her to cry, and added:

In retrospect I realize it is the lithium. When I was on the full dosage I couldn't cry. I'd feel really upset and yet I couldn't cry. It really pisses me off because I couldn't let it out and there are times when I need to cry. When I started to come

off the lithium I was able to have a really good cry about the stuff from when I was hospitalized and just before. I was just sobbing. Now if it's appropriate for me to cry, I can. What a relief!

Pat related a similar experience: "I'm not just on lithium, but on antidepressants and antianxiety, so no wonder I can't cry. Everything is trying to hold my feelings in."

The women in the group inhibited the natural expression of tears because parents and caretakers had let it be known, in a variety of ways, from verbal humiliation to physical abuse, that crying is not allowed. Francisca found herself crying in the group several times and each time she apologized for her tears:

I haven't cried for years. I don't like crying in front of you guys...it's most embarrassing. I find it really hard. I feel really teary and I don't want to cry. I don't cry in public. It's something you don't do!

Francisca included: "My husband would get so angry at me if I cried."

Caroline noted: "For the longest time my dad was into this thing of being against crying. He had a hard time dealing with it when I cried."

Naomi's experience was similar. "I was just thinking. All the men in my life really don't cry. My father, I've never seen him cry. My ex-husband really had a hard time with emotions of any kind and I never, ever saw him cry."

In contrast with the other women in the group, Lynne was able to cry freely: "I can't stop myself from crying. I can cry when I need to and it's like losing twenty pounds off my back. I feel like I can see things better." Because she was not inhibited from crying Lynne was able to experience the positive benefits of releasing tears.

As I described in the Body Out of Balance section above, all of the women suffered from somatic symptoms associated with depression. Speaking slowly, in a low voice, Naomi referred to somatic symptoms: "I've got a lot of physical problems right now that I'm trying to deal with and that makes me feel depressed too."

Pat, recovering from a recent bout of depression, noted: "I had severe stomach pains. I couldn't eat, I had--I was very, very negative."

Lynne added:

Waking up in the morning, thoughts going through my head. Not being able to cope. I was getting really sick. My heart was pounding. I was sweating and

it's just not a great way to start off the day and it just gets worse as the day goes on.

Ariana is bulimic and appears to experience depression on a physical level. She has a number of illnesses: "I've got a kidney infection so I am on antibiotics, and my blood pressure is normal but I'm still getting headaches. Also, I'm bleeding again." At a later session Ariana said: "I was hospitalized over Christmas for this [bulimia] and came close to dying."

Francisca commiserated with Ariana: "I've had PID [pelvic inflammatory disease] for the past two years and I need to go in for intravenous antibiotics once or twice a year. He [her physician] says I'll eventually need a hysterectomy."

All of the women in the group were suffering from recurring viruses and bacterial infections and this prompted Naomi to say: "It's like my body is giving me a really strong message."

Lynne also spoke of feeling physically ill. "I've been sick and depressed. On antibiotics and antidepressants. I'm having a lot of headaches and had a severe one last night." Several times throughout the sessions Lynne spoke of having a backache. "My lower back is in a great deal of pain. I'm aching and in constant

pain and it's really getting me down... I can't work at my nursing job because I have a back injury."

Francisca disclosed that she was coping with a similar problem:

"I have tendonitis in my arms and shoulders for the first two weeks of gardening and I can't afford to take time off to allow it to heal. I also have arthritis in the base of my back." As I have demonstrated by means of the quotes above, there is clearly a strong theme relating to physical symptoms running through the lives of the depressed women in this study.

Distortions of Thought

People who are depressed suffer from disordered cognitive functioning in two major areas. One of these is negative biasing of thought patterns, which influences memories for past events, evaluations of present circumstances, and expectations for the future. I discussed the depressed woman's perspective on past, present, and future in the Temporality section above. The second area of cognitive dysfunction is impaired learning and memory. The women experienced symptoms relating to cognitive function and cognitive errors. For example, Pat described her inability to concentrate:

I was suicidal. I didn't want to live. To me, every day was--I didn't want to live through it. Every morning I woke up with an anxiety attack and I couldn't go out for a walk, I felt too weak, and so it affected my thinking. My concentration was off. What am I talking about? Oh God. I'm easily confused and it scares me. Normally I have a good memory and concentration, but not right now.

In a similar vein, Eureka noted: "I have trouble making decisions. I'm really scared, really anxious and hyper, and can't sleep."

Several of the women spoke of feeling confused or paranoid. Some had difficulties with their memory, others with making decisions. These cognitive impairments were noted by Wright and Salmon (1990). Lynne described what it was like for her:

Last week I was really depressed. I was down. When I got up in the morning I couldn't cope. I didn't have any energy. My mind was paranoid. I was thinking up things in my mind and I didn't even know if they were true. But they were true in my mind.

Naomi also spoke about paranoid states of mind: "The last few weeks I've been just lying depressed and just waiting for something. I've been feeling paranoid and in

the last few days it's just felt like the bottom has dropped out."

On several occasions throughout the sessions Eureka stated: "I have trouble making decisions."

Pat echoed: "Sometimes my mind starts to take over and I can't rationalize."

A common cognitive error made by depressed women is to believe that they will never get better, as Eureka did: "I'm saying it to myself when I'm down in the dumps, I'm not going to get better. There's not a light at the end of the tunnel."

Telling the Story

The voices of the women are the data for this study of the experience of depression. All of the women in the group stated the necessity of talking about their problems to an understanding person. But it was difficult to find someone to tell the story to, as the following examples from the transcript testify.

Eureka described the despair she felt when she was depressed and did not have anyone in which to confide: "All I knew was that I was caught in the cyclone of paranoia and it was just too much. I remember ~~thinking~~ I've got to die because nobody will listen."

Naomi echoed the need to talk: "Like I, I'm the kind of person who likes to solve things on my own somehow, although I really need to talk about what's going on with me. I really need to talk with someone who will listen and understand."

Pat described calling the crisis line in order to talk to someone:

I was sitting and my mind was just going around and around and around and around. I thought I was going nuts and I called the crisis line. I didn't care what they thought of me and whether this is just a little thing or a big thing. For me, this is a big thing! It helped speaking to them and hearing a calm voice. They don't change anything for you but put it in perspective by being calm. They said, "Please call us anytime you're upset. Please don't forget." That in itself made me feel better.

Several of the women in the group voiced their concern that they were unable to get effective psychotherapy. Pat believed that she needed psychotherapy to deal with the trauma she experienced in her childhood, yet she was unable to talk to her psychiatrist: "He isn't interested. He only prescribes medication. He doesn't want to hear my story."

After a manic episode, Caroline was searching for the cause of its onset, and for ways to avoid a recurrence:

I need to speak to a woman, and yes--I need the one on one. I need to talk to someone. There's a lot of woman stuff inside that needs to come out.... He's a wonderful doctor [her psychiatrist]. He's got a great sense of humour and everything, but he just looks at one aspect and doesn't get into psychotherapy, because he doesn't have time and he's sort of the old book type, and so now I'm just going through this whole process of searching.

At a later session Caroline reiterated the necessity of finding a psychotherapist:

So I'm starting to find some links as to why that happened [manic episode]--which is really, really important to me, because the doctor that I have deals strictly from a pathological, here take the drugs, we'll level you out. I don't have time to talk. And he's a good doctor, and he's got me to this point, but I need to have more.

Lynne also had a difficult time finding a psychotherapist. "I went to Mental Health when I was really depressed, and they said there was a six month waiting list unless you're suicidal, and I said, 'okay I'm suicidal'; I need to talk to someone."

Francisca, who had repeatedly attempted to get professional help when she was depressed, reflected on Lynne's dilemma with anger:

That makes me really angry. I really needed to see someone to talk to, like a psychologist, and because I don't have the money and can't afford it, nobody is going to help me, even though I need it the most, because I can't pay them to help me. Quite often it's the people on welfare who can't afford it who need it the most.

Lynne enrolled in the group because she was unable to obtain individual psychotherapy. In order to tell her story, Lynne was forced to overcome her fear of speaking in a group:

When I first heard about the group I said no because I'd never been in a group. I'm really good talking one to one and a group scared me. I decided to come because I've just been going over my problems on my own and I need others to talk to.

Some depressed women have difficulty telling their stories because they were silenced by adults who did not want them to tell about abuse, or by adults who were not willing to listen in a caring manner. Ariana recounted such a silencing: "I was sexually abused by a babysitter, my parents friends' son, so I could never tell anyone.

Also by my uncle.... I never talked to anyone about it before."

Pat was also silenced: "I never had a childhood and the pain of it is coming up. It's wanting to be told... I was never allowed to talk about it before."

Francisca summed up her experience: "I never have had the chance before this to cry and talk about myself, and be listened to, and it hurts."

Some of the women used journals to write out their problems when it was not possible to talk to anyone. Francisca used poetry in her journal to describe her experience of depression: "I do write things down. I love to write poetry. I wrote five poems yesterday. It's my dream one day to be published. I probably never will be, though." Following is an example of her work:

*Into this world we come with trusting heart and
lusty lung.*

*Slowly we are shaped by father's hand and mother's
tongue.*

How we play and where we live

All seem to take part

In how we learn

But as we grow, work and play

We sweat to learn and find our way

But in the end it is oh, so clear--

That no one gives a damn.

Eureka explained her approach to journal writing: "When I write in my journal, I try and combine the rational part of me with the heart or emotional part... I need to write for me." Eureka's journal writing has provided her with valuable insight:

Yesterday I read my journal from last year, on exactly the same day, and I realized that nothing has changed. I've still got a man living with me. This guy that I was living with from November 18 to November 25--I wrote in my journal that he was wonderful. We were having fun, and the next thing I know I was calling the cops because he was beating me up. How much was I bullshitting myself? And it's almost like it's repeating itself again this year. The other guy was an alcoholic too, but he was a psychopath. This one now is like Harvey, you know the invisible white rabbit. He wouldn't harm a fly, but he's got his problems too. Anyway, I'm doing the same thing again this year that I did last year.

Out of desperation to make sense of her world, and, because she did not have anyone to talk to, Caroline turned to writing in a journal:

I began writing a journal out of fear when I was a teenager. I grew up in a small community and I was

the oldest. When I was in the trauma that was the only way I could figure it out. It worked for a long time and now I use it more as a record of what's going on with the day to day things. It's amazing the patterns we do over time.

Caroline did not have access to the wisdom of caring adults or peers in her adolescence; thus she was forced to make sense of her world by writing in her journal. Both Caroline and Eureka realized that they were able to track patterns in their behaviour over time as a result of writing in their journals. Tracking behaviours was valuable to Eureka since it clearly demonstrated, in her own handwriting, that she was participating in destructive relationships, and that she must change those behaviours.

From Victim to Survivor

Sexual, physical and emotional abuse of women is slowly being acknowledged today, yet there is still a great deal of silence surrounding abuse within society. There are many more victims of abuse than the immediate victim; abuse affects whole families. Six of the women in the group were abused by their husbands. Ariana claimed: "I've been separated for a year or so and I've been harrassed by my husband since. He just won't accept it."

Francisca's husband walked out on her and the children without regard for their financial or emotional welfare. She spoke slowly, choking back her tears:

I've recently come out of a pretty dramatic separation. My husband left me with three small children with one day's notice...I don't know how I'm going to cope financially or emotionally. I'm really depressed. It all feels pretty hopeless.

In speaking of her ex-husband, Francisca said:

I'm too afraid to make him angry because he'll make the kids suffer. He'll call and say I'm coming to see you on Sunday to the kids, then call at the last minute to say he's changed his mind. The kids are his weapon and I can't control it.

Naomi identified with Francisca: "You see, mine did the same with me. He used the kids as weapons. So I'd think I can't make him angry. I can't ever make him angry or upset because he won't let me see my kids." Francisca continued:

Every time I see him, I'm walking on eggs around him so that I don't get him upset or else he'll withhold child support... My ex-husband is really emotional. He gets angry easily and really scares the kids. I know he won't hurt me, but it's real scary for the kids. He's a lot bigger than me so I can't just

hustle him out the door... I've always been afraid to piss him off. I'm frightened he'll yell at me, and I'll go to any lengths to keep him from getting angry. He can't talk to me without getting angry.

Ariana also felt controlled and abused:

My husband is playing mind games with me. He watches me from outside the house, he goes through my garbage, he telephones all day long... Last week he called me up and asked me how my ultrasound went last Thursday, and if I was pregnant. He found the requisition papers in the garbage. I felt really invaded--scared.

I inquired if she was frightened of her ex-husband:

I'm not [frightened] of him because I know he's not going to harm the kids. If he's going to harm anyone it'll be me. I feel like I'm trying to stand up and I've got things attached to my feet and I can't shake them off.... I'm so angry and frustrated with it.

It's two years. It should be over. Everyone told me eventually he'll leave you alone and he hasn't left at all. He steals my garbage. Its so gross. I'm so mad. I can't do anything so I hold it back and hold it back. It's so hard. When you go out and he starts yelling obscenities at you across the parking lot and everyone knows and I just want to disappear.

Another thing that infuriates me is that he uses the kids to get information on me. He grills them when they're over.

Sometimes it is the children who are victimized by an abusive husband; other times it is the wife. Francisca's story is an example of the first case, and Ariana's of the second. Francisca realizes that her abusive ex-husband will not harm her, yet she fears for her children. Ariana clearly understands that her ex-husband will not harm the children. Instead, Ariana is the one in peril.

Women who are victimized and abused as children are at high risk of entering abusive relationships (McGrath et al., 1990). They are not educated in how to take care of themselves. Francisca is an example of the above. She describes her father as an alcoholic and her mother as cold and distant. She recalled being victimized as a child yet unable to tell anyone in order to get help:

I remember in Grade One being terrorized by the other kids after school, being tied to a tree and beaten and humiliated and thinking I was going to die there. I got beat up every day and I was too scared to tell anyone. When I was fourteen my father died. I was devastated. I got raped when I was fourteen--that's how I lost my virginity. I was staying with foster parents here in Victoria in order to be with my

father while he was dying and my foster father raped me! I've never told anyone that before.

Ariana's story was similar: "I was sexually abused by a babysitter, my parents friends' son, so I could never tell anyone. Also by my uncle." Both of Ariana's parents were alcoholic and abusive. She describes her father:

He used to say, anytime I made him angry: "you're the cause of this. I'm going to have a heart attack and die. It's your fault." I moved out when I was sixteen because every few days he'd say I was killing him, and I couldn't live with the guilt!

Eureka, when adolescent, "was going with a guy who beat the shit out of me [her]." Her current partner is abusing her. Because she has never been treated with integrity and respect she does not understand how to react to this abuse: "My boyfriend says something negative at me and when I start to react angrily he says he's only teasing and joking and hugs me and I get confused. This happens repeatedly."

It is easy for people to perceive themselves as victims, as has been demonstrated in studies of the Stockholm Syndrome (Kadish, 1983). The Stockholm Syndrome was identified in 1973, after four people held captive in a Stockholm bank vault for six days became emotionally attached to the robbers. The hostages came to perceive

the police as the "bad guys" and the captors as the "good guys," and a social bond developed between the captors and captives. It appears that it only takes a few days in captivity for hostages to become dependent, passive, approval-seeking, empathic with their captors, sympathetic to their cause, and grateful to their captors. These behaviours have been consistently observed in political prisoners from different cultural backgrounds. As stated above, females who were abused as children are at high risk of entering into abusive relationships. They form social bonds with their abusers in much the same way as did hostages of the Stockholm Syndrome. One easily imagines that the effects of physical, sexual, and emotional abuse perpetrated by a parent throughout a child's life, especially in light of the biological dependency of children on their parents, would create a social bond of dependency on and empathy for their abusers. All of the women in the study experienced abusive behaviour from a parent or caretaker. For example, Pat's experience of abuse began with a childhood spent in a concentration camp and progressed through a number of abusive relationships. Pat realized that she needed to learn new skills and information so that she would no longer be victimized:

I would like to work on relationships. I am a victim in relationships. It has been this way much of my life. With my husband and now with my mother. I don't like feeling stupid and put down in relationships...I allowed other people to walk all over me. I'm just starting to say: "Hey, lay off. That's it. No more." It's a terrible feeling [to be victimized]--you feel so helpless. My ex-husband used to put me down so often. I was ground into the floor. I want some respect. I want some freedom. Mostly respect. I asked her [her mother] to respect me as a grown person. My oldest son rejects me. It really hurts. He's very resentful towards me and I think its bordering on hate.... When I saw my family physician I said, "I am hurting so much I don't want to live." I was living against my own will. I told him that and he said, "What else is new?" I didn't go back to him. I'm angry with him. You see when I get sick my self-esteem is way down. I don't have confidence I cannot stand up for myself. I just sit and take it. No initiative or directions. I lose all direction.

It appears as though virtually every relationship in Pat's life has an abusive element, beginning with her painful childhood, continuing through her marriage, and finally

coming full circle with her sons' feelings of resentment and hatred towards her. Now, as an adult woman in her late fifties she is still trying to win respect from a mother who has no intention of giving it to her. She is even denied the respect she deserves from her physician. Pat believes that she is somehow defective. She does not understand that she acts like a victim because she has never been treated with the love and respect that is necessary to develop healthy self-esteem.

Because abuse was a central issue in almost all of the women's lives I attempted to teach them to take charge of their lives. For example, I used role plays in order to reenact abusive scenarios familiar to the women, for the purpose of helping them to develop new assertive behaviours. The women discovered that they habitually tended to behave as victims in their relationships. As each one discovered her ability to use an assertive voice, she was supported and encouraged by the other women in the group. I observed a domino effect: hearing one woman's experience encouraged another woman to experiment with new assertive behaviours which led to a gain in self-esteem and authenticity (J. B. Miller, 1986).

Francisca was one of the first women in the group to experiment with new assertive behaviour:

As a result of this group and talking to you guys I've come to some new realizations about myself and my ex. I realize how violent and unfair he treated me and the kids.... I stood up to him [her ex-husband] last Sunday for the first time in my life. It was our anniversary, and he was a month late with the support payment, and I was feeling alone and broke. He came by and said: "I just want to give you a hug and wish you happy anniversary." I said: "you haven't come by in four weeks, I'm feeling bad enough about our anniversary. I do not wish to see you." It is the first time I ever stood up to him. It stunned him. I felt strong. He looked at me and said, "I think I made a mistake in leaving," and I said, "well it's a little late for that."

Ariana also learned to take charge of her life.

Everyone cheered for her as she told the story of her recent victory:

On Sunday I threw my husband off the property because he was abusive to me and the kids. Six months ago I'd never have had the nerve. I said: "you get the hell out of here before I call the police." I'd never have risked him getting mad at me.

Eureka discovered a new sense of herself as a result of seeing the changes in the other women and by being confronted on her self-abusive behaviour by the other group members:

I'm learning things about myself now because of this group and I realize I have to make some changes. I can help other people with their problems. I'm very capable. I'm not weird or strange or insane. That was one of my biggest fears, that I was insane. I'm not insane. It was just like a yoke had been taken off my neck, and last night I was thinking I was insane. There is like a steel in me that is very calm, rational, humourous, intelligent, okay kind of person.

Pat realized she needed to make changes in her life. She observed the other women and she gradually found her voice:

I'm the victim always myself. I allowed other people to walk all over me. I'm just starting to say, "hey lay off! That's it! No more!..." I also terminated a relationship of ten years with a friend who was abusive to me. We had nothing in common anymore. We were miles apart. I felt empty when I was with her. It's so wonderful to have a support system. I could

not do what I've done for myself these past weeks if I'd been alone.

McGrath et al. (1990) coordinated a task force in the United States for the American Psychological Association, with the goal of researching women and depression. These authors reviewed several studies which showed that women with a history of victimization in interpersonal relationships tend to be diagnosed with depression at a higher rate: "Victimization in interpersonal relationships is a significant risk factor in the development of depressive symptomatology in women" (p. 28). McGrath's et al. statement supports the conclusion I have drawn from my study of the women: all seven of the women in the group were victims of abusive relationships, and their depression appears to be related to such relationships. McGrath et al. also reported that what is clinically diagnosed as depression may be long-standing post-traumatic responses to experiences of intimate violence and victimization, such as childhood sexual or physical abuse, marital or acquaintance rape, wife battering, sexual harassment in the workplace, or sexual abuse by a therapist or health care provider. In the present study, several of the women reported sexual, physical, and emotional abuse as both children and adults.

Coping Strategies

"How do you cope with depression?" I asked the women in the group. My purpose was to enable them to recognize their strengths and discover their own resources for overcoming depression. The women's responses indicated a range of resources and coping strategies. With regard to employment, five of the women were employed in full time jobs in order to support themselves and their children. Somehow they were able to cope with the pain and lethargy they reported as symptoms of depression. The other two held volunteer positions. With regard to parenting, two of the women were single mothers with young children at home and appeared to be doing everything possible to make their children's lives happy and healthy. Managing depressed affect was achieved by using a variety of coping strategies, which I found impressive in their practicality and creativity. Following are examples of these coping strategies.

Pat not only had a method, but also a back-up plan when her first method failed:

I focus on something beautiful, like flowers in the park. Now they are gone, of course, so I look at a picture of a little girl sitting under a tree, reading, and the sun shines through the leaves, and

the grass is a pale green, and it's peaceful, and I look at that, and I really see that picture, and feel peaceful... walking in Beacon Hill Park. I love flowers, seeing the trees beginning to bloom. Also calling a friend, talking to others with the same problem, helps.

Naomi also found walking to be an effective antidote to depression. "I find walking is helpful. I feel at peace. I go down by the water and just sit there. The sound of the waves really helps."

Francisca used a similar method: "I have a beach I go to, and that makes me feel better. It's relaxing. Watching the waves and hearing them will calm you down. It's peaceful there. I also like music."

Lynne realized that what may be comforting to others does not work for her: "I can't handle music right now. It's too painful. It's all about love and relationships, or being happy, and I can't listen to it." Lynne recognized some of her own coping strategies: "I've been writing a lot, and walking a lot. I met a friend yesterday for lunch."

I asked Eureka how she coped with feeling depressed, and without hesitation, she answered: "Going to the beach, writing, talking to a friend."

Pat discovered that working and involving herself with other people reduced her anxiety and obsessive thinking: "It's volunteer work but I feel safe and have a good time there."

Heavy physical work enables Francisca to cope: Weed a garden. It's the most peaceful therapeutic thing there is--to play with earth. When I'm in my garden I really get caught up in my life. It helps me to figure out where I'm at, and I sometimes discover that I'm talking out loud to myself. It gets me going, and whenever I get the urge [to drink or take drugs], or get stressed, or uptight, I go outside and start digging in my garden. I push myself to the point of exhaustion. I know I have lots of problems still to deal with.

Writing is a coping strategy that some of the women used. Naomi, for example, liked using a method that I and other therapists often employ: "Sometimes I write letters to people, really angry letters, and just keep them or burn them. Then I feel better." Naomi also voiced and clarified her feelings of sadness through poetry and painting. The following is an example of her writing:

*Winter blue, cold, damp, dark,
Cloudy, rainy days unfolding endlessly
There is no me.*

*Clouds raining,
Pushed their way skyward from the earth
With promises of warmth, but still are cold
My sun will not be warm,
Coldness creeps through me,
I'm not even feeling my thoughts.
Where is the fire
That I might creep near?*

I asked the question: "How many of you are able to place a high priority on taking care of your own needs?" My question was met with laughter; each of the women believed that it was selfish to take care of her own needs before everyone else in the family was looked after.

Caroline stated: "It's hard to do. I know for myself it's way easier to look after other people than to look after myself [Everyone laughs in agreement]."

During the course of the group the women were forced to revise their thinking about "selfishness" in order to develop healthier ways of coping. Naomi's experience exemplifies the benefits of taking care of oneself:

I've discovered that what I really need to do--a really good indicator for me is: I start to feel really tired, so what I need to do is, I need at least an hour by myself, at home, completely quiet, and just closing my eyes. Then I felt rejuvenated

and refreshed and it's great. And if I make myself do that, it works, and I can carry on.

Similarly, Pat stated: "I'm learning meditation, T.M. I've been doing it for six months and since then I don't have cold, clammy hands any more. I don't have cold, clammy feet anymore. My anxiety level--I can control it better than I used to."

Francisca discovered that having a child care worker come in to her house for one week-end a month enabled her to get away on her own, and, in fact, enabled her to be a better parent since she was feeling happier and more content.

As stated above, I instructed the group in coping strategies. Furthermore, the group members helped each other with coping strategies. Group members were especially influential and credible when they had previously experienced a difficulty that a member was currently struggling with, as illustrated in the following example. During the final group session, Eureka spoke of the pain and despair she felt about her present situation, in which she was attempting to leave her alcoholic boyfriend, find a place to live on her own, and deal with her addiction to drugs and alcohol. Her usual methods of coping were not working and she was at a loss to know what to do. She turned to me and her fellow group members for

help: "It is scary to think about it and it's painful, and boy I'm going to make enemies and be isolated, and not have any friends. These are all negative, scary things. I feel too frightened! So what do I do?"

Addiction to drugs and alcohol was familiar to Francisca, who gave Eureka the following advice: "I was always taught to write a do list and a don't list. A positive and a negative. For every situation or problem, a positive or a negative." With interest Eureka responded, "You mean I take a problem and list all the positives and negatives?" Francisca replied, "Yes, and another thing to think is, the very worst that can happen is they'll say no, but you can always turn that no to a yes." It was evident by the excitement on her face, and in her voice that this advice held significant meaning for Eureka.

It was a new experience for the women to be asked how they coped; they were familiar with being told what to do, and what medication to take, by professional helpers. They began to realize that they had intrinsic knowledge and abilities that had helped them cope with depression, and thus could learn to trust themselves more.

CONCLUSIONS

The phenomenological researcher uses his or her own experience as the starting point or the entry into the research. Therefore it is fitting to summarize my personal experience in conducting this research. I hoped that I would discover some truths about depression that would somehow prevent me from succumbing to the pain and despair experienced by my mother and grandmother. My search led me to study the meaning of depression to women. In retrospect, I think that leading the group and writing the dissertation have helped me accept the productive aspects of depression more, and to fear the debilitating and painful aspects less. While conducting and writing this research, I have attempted to follow the advice given by Rilke (1986) in Letters to a Young Poet:

Go into yourself and see how deep the place is from which your life flows; at its source you will find the answer to the question of whether you must create. Accept that answer, just as it is given to you, without trying to interpret it. Perhaps you will discover that you are called to be an artist....have patience with everything unresolved in your heart and try to love the questions themselves as if they were locked rooms or books written in a

very foreign language. Don't search for the answers, which could not be given to you now, because you would not be able to live them. And the point is, to live everything. Live the questions now. Perhaps, then, someday far in the the future, you will gradually, without even noticing it, live your way into the answer" (pp. 9-35).

I have lived the question throughout the process of doing this research. In the three years since the group terminated, I have discovered that when I experienced symptoms of depression, memories of the women's descriptions of their experience surfaced. I would find myself identifying with Francisca, or understanding what Ariana meant by a certain phrase, and I realized that I used similar coping strategies. For instance, I found comfort by working in my garden or sitting on the beach and listening to the sound of the waves. By paying close attention to my own experience of depression I have found that it is essential for me to give in to painful feelings. I have learned to cry when I feel like crying; to write about painful memories in my journal; to write letters (whether I send them or not) to people who have hurt me; to nurture myself; and to allow others to nurture me. These and other practices, such as talking to someone

who is understanding and empathic, have helped me to heal and to come to a deeper understanding of myself.

The act of writing this research has been frustrating and painful at times, as well as deeply rewarding. At various stages in writing I found I needed solitude to think and reflect without any distractions. During such periods I would go to Queenswood, a convent in the woods, and spend a few days immersed in reading and writing about depression. I took walks through the woods and down to the sea and meditated on what I was learning. The solitude and the peaceful environment enhanced my ability to come to a deeper understanding of the research literature, my own experience and the experiences of the women.

Themes in Summary

Eleven themes emerged from the thematic analysis of the transcripts, as described in the Findings and Discussion. These themes were selected because they seemed to me to embody the most salient aspects of the women's experience of depression as it was expressed in the context of the group process. My purpose is not to limit women's experience of depression to these eleven themes; it is quite possible that if a similar study were

undertaken with a different group or different leader, then differences might occur in the character or the emphasis of certain themes. The purpose here is to include, not to limit. Although it is impossible to do justice to the richness and depth of the women's voices in the transcript, in the following paragraphs I will attempt to communicate to the reader the essence of the eleven themes.

Intimate Relationships

The theme of intimate relationships emerged as the dominant theme in my analysis, as shown in the Findings and Discussion. There is an interesting difference between the way that the women in this study were provoked into growth, and the way men grow, as shown by the study performed by Levinson (1973). The men in his study experienced personal growth in their lives as a result of crises in occupational aspirations. The women in the current study experienced growth primarily through crises in their relationships. In addition, the most dramatic examples of growth and change in the women in the group can be seen in the stories of women whose relationships ended.

The loss of a relationship had profound meanings, such as the loss of an identity, loss of a dream, or loss of a friend and confidant. In more practical terms it meant the loss of financial security, or the loss of a partner to help with the responsibility of parenting. All of the women in the group voiced the devastating effects of divorce. For example, some had been hospitalized subsequent to separation because of bipolar episodes, suicidal risk, and psychotic depression. In others, separation was accompanied by physical symptoms such as migraine, uterine bleeding, and pelvic inflammatory disease. Common to all was the experience of feeling overwhelmed by the challenge of facing life alone, the experience of despair, and the experience of loss of the self. These women needed to learn to handle independence before they were ready to survive the vicissitudes and challenges of intimate relationships.

As stated in the Findings and Discussion, all of the women realized in retrospect that they had become stronger as a result of being forced to develop independence. The productive aspect of depression is that, in the recovery process, it forced the women to discover a new relationship with the self: they did not need men; they could be self-reliant. They discovered the ability to set goals and make decisions. Two of the women returned to

school to pursue new careers. Some of the women are still struggling, uncertain of their identity and the future. The women also learned that they could have deeper, more spontaneous, and joyful relationships with their children. Depression forced them to re-evaluate their relationships with their husbands. They often came to the conclusion that these relationships were damaging to themselves and their children. After extricating themselves from destructive relationships, the women were free to develop more intimate friendships with other women and family members.

Living Environment

Many of the women realized that their living environments contributed to their depression rather than providing a warm and comforting refuge from the pain of life's struggles. Occupying dark, oppressive apartments, six of the women failed to keep their rooms tidy, and lived with people who contributed to an oppressive home environment. For example, Pat felt trapped and unhappy living in an apartment with her mother. She avoided going home, spending entire days walking the city streets in the rain. She felt alienated and homeless as she had as a young girl in the concentration camp. This exacerbated

her depression. Two other women discovered that the emotional climate in their homes improved after their husbands had left. They described a new-found sense of freedom and peace. The group helped the women to take stock of their living environment and to examine its contribution to depression. Six of the seven women changed their living environments as a result of this sort of examination.

Experience of Time

The women who claimed to have been depressed for most of their lives seemed to experience time as empty, to be filled with repetitive and sometimes trivial rituals, such as smoking cigarettes and drinking cups of coffee. Without a sense of hope for a better future, there is no point in using time wisely, or creatively, or in planning towards future goals. T. S. Eliot (McMahan, Day, & Funk, 1989, p. 573) described how meaningless time can feel in *The Love Song of J. Alfred Prufrock*:

In a minute there is time

*For decisions and revisions which a minute will
reverse.*

*For I have known them all already, known them all--
Have known the evenings, mornings, afternoons,*

*I have measured out my life with coffee spoons;
I know the voices dying with a dying fall
Beneath the music from a farther room.
So how should I presume?*

The seemingly endless progress of depression gave time a stretched-out, slowed-down quality. My impression was that a single hour could feel endless, as if the melted, distorted clock painted by Salvadore Dali represented time for them.

Another aspect of time is the yearly cycle of the seasons, which had a relationship to symptoms of depression. All of the women described the fall and winter months as dark and depressing. Their negative experience of fall and winter may be related to seasonal affective disorder, which is treated by phototherapy, as described in the Treatment section in Chapter Two.

A productive aspect of depression is that it forced the women to pause and evaluate time in their lives, past and future, and to realize that if they do not make major changes they will die without having ever really lived. They had to learn to make time meaningful, by implementing life changes, such as returning to school, changing careers, or ending a destructive relationship.

The Body Out of Balance

The women utilized a portion of every session to discuss their physical symptoms; what they described is the body out of balance. There was a surprising amount of physical illness experienced by the women in the group. In every session during the twelve week group, one or several of the women complained about current illness or pain, from conditions such as pelvic inflammatory disease, migraine, endometriosis, or bladder infections.

The positive aspect of depression with respect to the body out of balance is that the physical symptoms forced the women to pay attention to the fact that something is wrong. Like pain, the symptoms told them to stop and pay attention. Unfortunately, when they were depressed, the emotional pain was often invalidated by family or friends. The secondary gain, consequently, is in becoming physically ill in order to be listened to and nurtured by those close to them, or to call attention to the seriousness of the problem. The physical symptoms validated their emotional pain. Also, it is socially more acceptable to be given a medical diagnosis of migraine, back pain or ulcers than to face the emotional pain which is expressed by those physical symptoms.

Language

The key to understanding a woman's depression is through her use of language. Many of the women in this study defined themselves according to their diagnosis. In our society, women with emotional problems are often given identities by clinicians in diagnostic terms. Women with physical problems have identities independent of their illness. Consequently, our language makes important distinctions between emotional and physical illness. A person has a cold, has cancer, but a person is depressed, is schizophrenic. The verb to be, used in the emotional illness, implies identity, while the verb to have implies ownership. The identification of the woman with the illness has important implications. For example, Pat was misdiagnosed as schizophrenic and treated as such for nineteen years. Her diagnosis was the major factor in the court's decision to award custody of her children to her husband. Naomi also lost custody of her children, in her case because of a diagnosis of manic depression. The label manic depressive has a perjorative connotation in the eyes of our society. When a woman is labelled in terms of an emotional illness such as depression, the language used affects her fate. Rather than receiving

support and compassion she is faced with discrimination and avoidance by others.

The women found interesting and effective metaphorical ways to express their pain and feelings in language, despite the fact that our language is inadequate for the expression of emotional ideas. One woman expressed her helplessness to depression as "my soul is up for grabs". The Chinese symbol for depression is composed of two interesting ideographs: the heart sign enclosed by the doorway sign, entrapping it. The pictorial representation in the Chinese language concisely depicts what words are unable to convey about the experience of depression.

Medication

The theme of medication embodies the women's experience in understanding how medication both helped and hindered them on their road to health. The women's experiences with antidepressant and anxiolytic medication led them to realize that medication sometimes is very effective on a short term basis, but is not a cure. At times they found medication useful to help stabilize them until able to make the necessary changes to give their lives meaning. Medication used as an interim measure, as

a component of long-term therapy, has irrefutable benefits. Three of the women, who were diagnosed with bipolar disorder, discovered benefits from lithium medication. Unfortunately for many, the side effects of medication, such as dry mouth, dizziness, constipation, and confusion, were debilitating. Some of the women on medication appeared to lose the ability to cry. Caroline, for example, felt better after the return of her emotions upon discontinuing medication. Previously she complained: "I'm on cruise. I've been levelled out by the medication and I feel there is very little emotion in my life right now." Medication can prevent healing through addiction, as Eureka found: "I don't know about pills. I feel like I'm addicted to them now. Anything that happens, any little thing, I feel like I have to take a pill."

It is interesting to note that the Aristotelian tradition contains a belief that upon recovery from depression one finds new capacities of intellectual depth, wisdom and learning. In contrast, our current society views depression as an illness with a stigma, to be concealed and denied (Kaplan & Sadock, 1985). In this study, symptoms such as emotional pain appeared to be masked by the medication. Masking symptoms was not sufficient, in my belief. I suggest that the women needed to change aspects of their lives that were contributing to

or maintaining their depression. For example, they needed to address social issues such as poverty, abuse, and inequality. In the current study, medication for the women was sometimes used as an agent of social control, and not an agent of healing, an issue addressed by Szasz (1974).

Symptoms

Four symptoms stand out amongst the many described in the eleven themes, because they were experienced by the women as recurring, overwhelming, and debilitating. The four key symptoms are: lethargy, immobility, anxiety, and frenzied agitation. Surprisingly, these discomforting symptoms appeared to be beneficial to the depressed women. It seemed to me that lethargy and immobility forced the women to stop and examine their lives. Similarly, anxiety motivated them to examine what was disturbing or unsettling, stimulating a search to rectify the problem. Frenzied agitation may be a way of notifying the environment that there is a problem, an outward call for help. Six of the women described feeling as if they needed to cry but were unable to do so, suggesting that in depression the body is unable to utilize normal healing processes such as crying. A productive aspect of the

symptom of "non-crying" is that it may alert clinicians to the fact that something is wrong with the person's affect.

Distortions of Thought

The women in the group all experienced paranoid thoughts, debilitating confusion, and inability to make decisions. These are the symptoms of depression on which cognitive behavioural therapists focus. The main thrust of cognitive behavioural therapy is to change negative or distorted thoughts to positive or reality-based schemas. While I believe that this is necessary, it is not enough. Simply reversing thoughts will not allow depressed women to recover. The emotions need retraining also: the women need to learn to grieve, how to cry, how to deal with anger, how to be supported through recovery of traumatic memories, and how to ask for help.

The brain does not function properly in depression; perhaps the confusion and inability to make decisions keeps them from making major life changes while they are in the depressed state. The paranoid thoughts that some of the women reported may have developed as responses to childhood traumatic events involving intense fear, such as rape, incest, prolonged separation from a parent, or violence in the home. The positive aspect of such

thoughts may be to alert the community to the nature of the past trauma, and thereby stimulate understanding and healing on the part of the depressed woman.

Telling the Story

All women in the group had experienced the pain of needing to talk about their depression and the inability to find the appropriate people to listen. The essence of the theme telling the story is contained in the following quotation from Eureka: "I've got to die because nobody will listen." Some of the women discovered the benefits of journal writing as a substitute for being listened to by a caring person. They were able to experience the healing effects of pouring their deepest thoughts and painful feelings onto paper when they were unable to confide in others. It appeared that writing about their trauma promoted an understanding of self and others as well as being a powerful tool to discover meaning in their lives. Pennebaker (1990) has conducted research on the healing aspect of confiding in others. He notes: "Excessive holding back of thoughts, feelings, and behaviours can place people at risk for both major and minor diseases" (p.14). In light of the extensive illness among the women in the group clinicians must take heed of

the healing aspect of allowing women to tell their stories. A positive aspect of depression in this study is that it forced the women to seek help, to find a clinician who would listen to their stories. In doing so, they discovered that painful, often repressed experiences and stories needed to be revealed and witnessed for healing to occur.

From Victim to Survivor

Several of the women in the group described themselves as victims. The women believed that it was their fault that they were depressed, and this belief was reinforced by family members and clinicians who viewed depression as a problem. They were diagnosed as depressive, reinforcing the helplessness and the perception that they were defective for being depressed. Children were removed, and relationships terminated as a result of their victim status.

Group therapy served as a vessel for the women's journey from victim to survivor. The group appeared to have catalytic or synergistic effects on the process of finding strengths. The women pointed out strengths in each other, discovered strengths in themselves, and the cycle was repeated, yielding further growth.

It was rewarding for me to witness the transformation of the women from helpless victims to strong and powerful survivors with a new sense of self. Rather than accept their fate as victims, they discovered that they had choices about how to live their lives. Through taking control of their lives, asserting their needs, realizing the need for a supportive environment, understanding that they were not alone, and understanding that they were not to blame, they saw that they could live full lives rather than the diminished lives that they had considered their lot. They discovered that they would be better role models for their children as they took charge of their lives. Some were alerted to the fact that they were in dysfunctional relationships and that they needed to make profound changes. These were major discoveries, and appeared as revelations to the women. They had a sense of wonder in their voices when they realized for the first time that they did not need to serve everyone else first, that they were entitled to their own needs.

Coping Strategies

The theme of coping strategies is the only one to emerge as a result of my influence as therapist. I attempted to help the women to realize that they already

possessed resources within that were effective for coping with depression. Coping strategies such as meditating, journal writing, poetry, and gardening enabled them to draw upon their inner strengths and healing capacities. They enjoyed teaching their coping strategies to other group members and discussing the relative merits of each strategy. Perhaps the most important coping strategy to emerge from such discussions was the value and necessity of nurturing themselves. The natural and cultural trait of women is to nurture others. The necessity of nurturing the self was an important discovery for all of the women.

Final Words from the Women

As the final comment on the experience of group therapy, I will let the women in the group speak for themselves. The final session, which was attended by five of the seven women, is quoted below in its entirety, with extraneous comments deleted.

Lynne:

The group has come a long way, because of the mutual support. There is so much trust and acceptance. You can say whatever you want to say in this group and that's okay. I think I've grown a lot. I've quit

smoking, even with all I've been going through. We've all come so far. The depression is still there, but it's manageable now. Now when I get depressed it's still the same characteristics [sic]. I don't care, it's black, no one gives a shit so why should I? Beating myself up and worrying. Whereas now it's a matter of being aware: just like smoking is a habit--well, saying I'm no good is the same. Now I can say wrong. I am good. This group has helped me with self-esteem, taking the first step, writing [journal] and getting focused.

Pat:

I am asserting myself more and more, and meeting my own needs more. I feel very tired now, but I don't feel sorry for myself. The depression is much better. I am not suicidal now, even with this withdrawal [she was addicted to xanax].

Francisca:

Francisca reflected on her experience in the group: I cried all day Sunday. I cried about loneliness. I have been feeling lonely. I sat at the kitchen table and cried and I felt better after, relieved. My depression is a lot better. My sense of humour returned. I had lost it for a long time, but I feel alone and lonely. I feel a lot stronger. This group

has given me courage to go on--I'm not all alone. I've got the group. Now I can meet people without hiding behind anything, but it's still hard for me to meet people.

Ariana:

I still go up and down. Sometime I feel blank and have no feelings. I'm more happy than unhappy but not a real low. I have moments when I feel down and up but they don't last. I dreamt I had a baby boy. A birth within myself--like something's come to an end. I feel stronger than a couple of months ago. I got rid of a lot of garbage and I learned to say no to things. My personal life feels like it's too good now and that's got me worried! I figured out where my problems started from, and I'm not bulimic any more, because I can speak about my problems without holding them in. It was hard at first to talk, yet I don't feel depressed any more or alone. Before [the group] I felt all my problems were mine and I was alone. Now I realize the guilt went away when I talked in group. I made choices that were best for me at the time. My kids notice the changes in me and they're more carefree. This is the way it should be!

Francisca:

I notice the same with my kids. Especially J. He's more independent.

Pat:

I used to be really scared of groups. I had a bad past experience with them. I was really scared and I am not that way any more. Now I feel a lot freer [sic] to say what is on my mind. The depression is still there but I feel I will work through it as best as I can with support. I will continue to see my psychiatrist until my medication is totally straightened out and I am not in addiction any more. I have difficulties with authority figures and doctors because so much crap was dealt to me--because they did not listen to me. Now I'm shedding that--I am growing. I have progressed. I also want to tell you that I always felt very comfortable with everyone in the group.

Eureka:

I had the same problems with groups. I hated them. I don't like crowds--I have a fear of them. I can't go to movie theatres, and for that reason I have a problem with AA [Alcoholics Anonymous] too. This group gave me a lot to think about, the criticism and the support. I wish it would continue because I

really like it. Sometimes I felt insecure with the others because I'm not as good, but the support from the group was great.

The purpose of this study was to discover the meaning of depression to the women who experience it. The meaning of women's experience of depression was revealed in their words, obtained from the transcripts of the group sessions. As the above quotations illustrate, the women also discovered meaning for themselves. They discovered that the meaning of their experience of depression was embedded in their life stories. For example, they realized that growing up in abusive families and living with abusive husbands contributed to their depression. Their experience of depression took on new meaning. They realized that they could live lives that had more meaning, if they changed their lives. They discovered that they had to rely on themselves in order to change their lives, not on family, friends, or clinicians. All of the women made major life changes.

Future Research

One direction for future research is to study men's and children's experience of depression from a qualitative

perspective. A second direction for future research is to examine the possibility that physiological symptoms experienced by depressed women, especially gynecological symptoms, are related to the incidence, severity, or onset of depression.

Implications for Clinicians

The findings discussed in the summary of themes above are potentially useful to clinicians. I would like to highlight just a few implications. The theme of the body out of balance illustrates that physiological illness is a predictable component of depression in women. When conducting therapy, clinicians may find it useful to include an investigation of their patient's physiological symptoms. The theme of telling the story suggests that it is important for depressed women to be able to tell their stories. Three overarching implications of this study for clinicians are: a) the importance of investigating the meaning of symptoms, b) the importance of social and emotional support in the treatment of women's depression, and, c) the mental set or operating assumption that depression can be productive.

Investigating the Meaning of Symptoms

I observed in this study a connection between some of the symptoms of the women's depression and childhood incidents of incest. The women who reported childhood incest also reported physiological symptoms such as bladder infections, endometriosis, uterine bleeding, and pelvic inflammatory disease. These symptoms are clearly related to the region of the body where they were assaulted. While it is not possible to draw the conclusion that there is a causal relationship, in this study there appears to be a correlation between incest and gynecological symptoms. Clinicians may find it useful to investigate the meaning of various symptoms in depressed women. For example, recurring gynecological problems in depressed women may indicate incest.

Social and Emotional Support

In listening to the voices of women as they described their experiences of depression, I arrived at the following question: "How do we create a world that supports and encourages females to live their lives fully?" Several generations of psychological researchers have neglected to include the voice of women in their

theories on depression. Their theories rarely fit the individual woman's experience. Since Freud, personality theory has focused on the male to the exclusion of the female. Recent theorists are attempting to rectify the male-oriented perspective by studying and writing about women (Belenky, Clinchy, Goldberger, & Tarule, 1986; Gilligan, 1982; Jack, 1991; J. B. Miller, 1986). These authors have listened to the voice of women, and have redefined characteristics previously denigrated by our culture in a positive light. For example, behaviour formerly described as needy or dependent might be interpreted as aspects of women's relational ability. A supportive world for women would value their ways of relating that are different from traditional male expectations.

Belenky et al. (1986) described women's five ways of knowing: silence, received knowledge, subjective knowledge, procedural knowledge, and constructed knowledge. Clinicians can support women by including women's ways of knowing in their study of psychology rather than trivializing it by labelling it women's intuition. A supportive world for women would encourage and include women's voices in therapy, research, and education.

The issue common to many of the eleven themes described in the Findings and Discussion, is the issue of support: support from husbands, friends, family, social agencies, and clinicians. For all of the women, support made the difference between healing and persistence of symptoms. In particular, the supportive effect of group therapy was a major factor in their healing. The implications for researchers and clinicians are: that female role stereotypes must be challenged; that women must be encouraged to develop self-reliance; that anger must be explored and expressed; that assertive skills and self-nurturing skills are required; that women must form alliances with each other to decrease isolation and increase mutual support; that women are the experts when it comes to their own experience and must be allowed to tell their story. The following quote from Eliot (1952) imparts the unspoken fear of many depressed women:

*I should really like to think that there's
something wrong with me--
Because, if there isn't, then there's something
wrong,
Or at least, very different from what it seemed
to be
With the world itself--and that's much more*

frightening!

*That would be terrible. So I'd rather believe
There is something wrong with me, that could
be put right.*

--Celia to Sir Henry, from The Cocktail
Party Eliot (1952)

Productive Depression

Many aspects of the above eleven themes illustrate that depression can be productive. Gut (1989) has already introduced the idea that depression can be productive: she describes the emergence of a healthy adaptive function of depression leading the depressed person to becoming more psychologically whole and with a greater knowledge of our inner selves. We need to investigate the productive aspects of depression rather than treating depression as a disease. Depression stops women from functioning in their old ways and forces them to re-evaluate the way they are living. They discover that they cannot cope anymore and must find new meaning. Depression results from a thwarting of the drive towards growth and self-fulfillment. I believe that the therapeutic effects of the group, such as support, telling their stories, learning about depression, and discovering coping

strategies, enabled each of the women to experience some productive aspects of depression.

In conclusion, the productive possibilities of depression are illuminated by William Styron's eloquent description of the journey to the other side (Styron, 1990, p.84):

For those who have dwelt in depression's dark wood, and known its inexplicable agony, their return from the abyss is not unlike the ascent of the poet, trudging upward and upward out of hell's black depths and at last emerging into what he saw as "the shining world." There, whoever has been restored to health has almost always been restored to the capacity for serenity and joy, and this may be indemnity enough for having endured the despair beyond despair.

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APPENDICES

Ground Rules for Group - Victoria Mental Health Centre - beginning

1. Members commit themselves to attend weekly, every _____ from _____ up to including _____
2. If, due to some emergency, member must miss a meeting in advance of the meeting, he/she will phone leader or another group member to let us know he/she will not be present. (Any group member who misses three meetings without making arrangements will no longer be a member of the group).
3. Members will give two week's notice if they are quitting group.
4. Strict confidentiality will be observed regarding what is shared or done by other members of the group.
5. Members will not smoke in group.
6. Members accept contract not to make sexual overtures towards or have sexual relations with other members as long as they are in the group if they were not sexually involved with this person when joining the group.
7. Members agree to be "straight" with each other, to say what they are thinking and feeling, to give strokes, confrontations and feedback as much as possible.
8. Members will make commitments re what they will do inside and outside the group and report on these. Also members will know and enquire about each other's commitments.
9. Members agree not to kill themselves while they are members of the group.

I _____, consent to being a participant in this Study of the Experience of Women's Depression.

I understand that my participation in this research is completely voluntary and I may withdraw at any time. I also understand that I will be allowed to read the final transcript in order to modify or delete any portion that identifies me if I so wish.

I further understand that my participation in this study will be kept confidential. Any names or other identifying information will be changed in the transcript process. A pen name I have chosen will be substituted for my real name. Audiotapes of the sessions will be kept under strict security and will be accessible only to the researcher. The audiotapes will be destroyed upon completion of this study.

Signature _____

Date _____

APPENDIX C

Transcript of Session 1

Group introductions: November 8, 1989
(Opening remarks omitted)

Pat:

I live in an apartment with my mother and I have a difficult relationship with her. I have 2 boys in their early 20's who live in Toronto. My main interest is in flowers. I would love to have a flower garden. I became ill shortly after my first son was born. I was misdiagnosed for 19 years and treated as a schizophrenic. I was on antipsychotic medication which made me feel terrible--really sick. I was given massive amounts of shock treatment. Then someone diagnosed me as a manic depressive. It took me 4 months to adjust to lithium and I have been much, much better since.

Lynne:

I'm a nurse but I haven't been able to work at it for the past five years because of a back injury. I've gone through a separation from a relationship.

Naomi:

I'm an RN who is burnt out and would like to go back to school and study law. I'm at university studying now. My real interest is in art and dance. I'm divorced with 2 children who are in their father's custody and that's really hard for me.

Caroline:

I was diagnosed with bipolar disorder--for me. The manic episode was a really positive experience for me. I would like some one-on-one counselling as well as this group to help me to understand more about this illness. It started last summer and we're not sure what caused it. Whether it was brought on by a depression previous to the manic episode or what? I'm on medication to control it.

Therapist:

Can you describe what your manic episode was like?

Caroline:

Very happy. Overly happy and I wasn't sleeping right. I

was sleeping maybe 2 hours a night. Maybe three and it just progressively got worse and worse. It was a really up experience for me. People describe it as a negative experience but for me--I was just right up there having a good time--just being super busy around the house. In retrospect it was bizarre behavior. It started to get irrational so that's where the manic is out of your control. My husband watched my behaviour getting more and more out of control and at first he got angry at me and told me to stop. He said you're doing this to me again, his previous wife has a history of mental disturbances and he said he never wanted to go through that again and here it was happening. I'm now on lithium, which is a start. Now I'm searching for reasons why it happened and if it will ever happen again. How can I control it? Can I do it without medication. My goal is to get off medication.

Naomi:

Last June--at the end of last June--I had been off the medication for 3 months and I'd told my psychiatrist I didn't want to be on it anymore. It was powerful, really powerful. I was out of control--not eating, not sleeping, the whole thing. Just as you described. And then about 3 or 4 months after that I felt really depressed. So it's like it swings one way then the other. I'm just now starting to come out of this depression.

Therapist:

Have you met other people who suffer from manic depression?

Naomi:

She's the first one. I thought I was the only one in Victoria with this disorder.

Pat:

I'm a manic depressive too. I don't go this way (pointing up) I go that way (pointing down) and I go so far down I don't want to live anymore. I've been down so many times because I've been misdiagnosed for 19 years and I've been down there so often I will never go off lithium. Since I've been on lithium I've seen progress and have been able to work on my problems so my advice, no my experience says to stay on it.

Naomi:

Before that were you given antidepressants to treat your depression?

Pat:

Before that I was treated as a schizophrenic. I was on antipsychotic medication which made me worse. And massive amounts of shock treatments. I must have had 70 or 80 shock treatments all in all. I would be worse when I came

out of the hospital. That's when I went in so that's why I wouldn't go off lithium--never. It took about 4 months to adjust to lithium but when I did I became calmer and more peaceful inside.

Caroline:

For me the manic experience was wonderful. Maybe that was because I had a really supportive environment. I'm not afraid of it happening again. Also, I think I could tell by the symptoms what was happening--if I was heading in that direction.

Lynne:

My experience with depression goes back a while. I've been trying to get back into the work force and I can talk about it rationally but I just can't get out and do it. I put in applications I know what I want to do but then something stops me from doing it. I don't know why it is--my self-esteem is low. For the past 3 years I've been living with a woman who had 2 kids and I basically took care of them and that went really well until we ran into a money problem. I couldn't get a job and that basically destroyed the relationship. Now I'm really lonely. I haven't let go of that relationship. I think I'm obsessed. I can't seem to let go. I've been on anti-depressants but they make me hallucinate. I listen to tapes when I'm depressed.

Therapist:

How do you feel about the group?

Lynne:

When I first heard about the group I said no because I'd never been in a group and I'm really good talking one to one and a group scared me. I decided to come because I've just been going over my problems on my own and I need others to talk to.

Therapist:

Pat, do you want to share something in terms of your goals in this group?

Pat:

Yes. I would like to work on relationships. I am a victim in relationships. It has been this way much of my life--with my husband and now with my mother. I don't like feeling stupid and put down in relationships. I am very lonely and I know the only way I can stop being lonely is by meeting people and spending time with people. I also need to overcome this feeling of being scared and discouraged.

Francisca:

I've been unemployed for years but I work as a gardener now because people ask me to work for them and I can bring my kids with me while I work. I've been feeling depressed for a long time. Now I feel numb. Because of my kids I have to keep going. I don't have a choice.

Pat:

Excuse me. In a way you are lucky because when I had my first depression I had a baby and 2 year old. I had no help - no nothing and because I had the 2 of them I felt the responsibility of them and that kept me going and it kept me going and it kept me going. It's a very good incentive when you have something like that.

Francisca:

I agree - When I feel overwhelmed and start to cry I have these 5 year old arms around my neck and I realize why I'm doing this.

Therapist:

How often do you feel these feelings Francisca?

Francisca:

Depressions?

Therapist:

Yes.

Francisca:

They've gone on for years. I can't say how often. It's more how often I don't feel depressed. What I really want more than anything is to go to University and get a degree. I had just gone back to school for 4 months when my husband left. I was doing so well.

Therapist:

Is there any way you can go back?

Francisca:

I just don't see how. We're barely surviving (Crying).

Therapist:

As you look around the rooms can you feel how your story is affecting the others? I feel it too. You're in a lot of pain.