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Adults' Perspectives of Causes and Influences on their
Depression

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Abstract

Depression is a debilitating disorder with prevalence rates increasing worldwide. New Zealand's rates are high compared to world statistics. How depression is conceptualized guides treatment pathways. Currently, anti-depressants are the most commonly prescribed treatment with emphasis on the symptoms of depression. However, long-term effectiveness of drug treatment is debated. Furthermore, depressive symptoms are common among other disorders such as Generalised Anxiety Disorder, as well as being normal signs of grief. Much research focuses on statistical measures of depression and related variables. There is a paucity of literature focusing on individuals' reflections of their experiences with depression. The current research utilized interview data collected one year after completion of a double-blind Dietary Intervention Study (DIS). Although the author of the present study did not conduct the interviews, she was authorised to analyse existing pre-recorded transcripts using thematic analysis. She explored, within a New Zealand context, the experiences of 13 previously depressed adults who agreed to be interviewed. Four identified themes are reported and discussed: *Stress and Anxiety – Causes and Consequences; Negative Attachment Styles; Maintaining/Unhelpful Factors; and Positive Perceptions and Assessments*. Predominant findings were stress and anxiety (general and social) as causal and maintaining of depressive symptoms, with avoidance (bottling, ignoring, distraction, procrastination, and shutting down) being the most common coping strategy employed. Common stressors included early trauma and being bullied at school, as well as negative attachment styles with parents. Poor communication styles were problematic and continued from childhood through to adult relationships. Both genders tended to view themselves and the world in a negative manner. Findings from this study suggest that the current medical model of depression is insufficient to conceptualize and guide treatment pathways. A social/contextual model might provide a more useful extension to the understanding of depression with context and individual experience being paramount. Discussion includes what participants found helpful or unhelpful to

assist clinicians in their decision-making regarding treatment. Additionally, there were unexpected findings specific to males regarding suicidal ideation and attempts, breakdowns, and the importance of being listened to without judgment. Incorporated are limitations of this study, suggestions for future research, and clinical implications.

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Chapter 1

Introduction

Depression is a common and debilitating illness problematic to all walks of life, young and old alike, with culture being no barrier (Susser, 2001). It is a world-wide phenomenon with lifetime prevalence rates ranging across cultures from 3.3% in Seoul to 17.1% in the United States (Kaelber, Moul, & Farmer, 1995). Comparatively, New Zealand rates of depression are in the higher bracket when judged against other world community samples of prevalence figures (Kaelber et al., 1995). Specific to New Zealand, in 1986 the Christchurch Psychiatric Epidemiology Study (CPES) uncovered prevalence rates of major depression ranging from 10% (ages 18-24) to 15% (ages 25-44) (Wells, Bushnell, Hornblow, Joyce, & Oakley-Browne, 1989). More recently, the New Zealand Mental Health Survey (NZMHS) released in September, 2006 reported prevalence rates for those similar age groups to be 15% (ages 16-24) and 17% (ages 25-44). The highest prevalence rate in the 2006 survey was in the age bracket 45-64 at 18% (Oakley-Browne, 2006). Not only have the overall prevalence rates increased, the age brackets have altered as to which age groups are the least and most depressed. It should be noted that both of the New Zealand studies used different editions of the Diagnostic and Statistical Manual of Mental Disorders and therefore had different diagnostic criteria, used different sampling frames, and had different questionnaire designs (Oakley-Browne, 2006). This makes it difficult to draw conclusive comparisons of prevalence rates. Additionally, both studies were retrospective. A recent prospective study of mental disorders within a New Zealand population uncovered a lifetime prevalence rate for depression of 41% (Moffitt et al., 2009). Moffitt et al. (2009) note that, while self-report surveys are useful, they tend to underestimate true prevalence rates.

Clinically, how depression is conceptualized guides best treatment pathways. Currently, anti-depressants are the most commonly prescribed treatment (Kotz, 2007; Sundhedsstyrelsen, 2007, as cited in Hougaard, 2010).

However, according to Hougaard (2010) there is little evidence that antidepressants are efficacious long term. According to Wakefield (2007, as cited in Kotz, 2007), the increased availability of these drugs has in turn increased the diagnosis of clinical depression. There is much current debate questioning the possible over-diagnosis of depression and subsequent overuse of antidepressant drugs. It is unclear whether the serotonin levels that these drugs apparently 'balance' are the cause of depression. In fact, in February 2007, the director of the US National Institute of Mental Health confessed that low levels of any neurotransmitter including serotonin were not the cause of depression (Levine, 2007). Levine (2007) purports that the focus on neurotransmitter levels, 'red herrings' (p. 48) in his terms, diverted attention from aspects of society and our lives, which are forever changing, which may be the very core of depression. Spitzer (n.d., as cited in Kotz, 2007) for instance, argued that the context in which the depressive symptoms occur must be taken into consideration, and that many symptoms of depression may in fact be normal signs of sadness which naturally occur in the face of many life events such as a broken heart, bereavement, loss of home, and forced retirement to name just a few. Loss of affection within a marriage is also highly associated with depressive symptoms (Levine, 2007). According to uncited experts, these normal responses to sadness may in fact be inhibited and the grieving process prolonged when antidepressants are the only therapy prescribed (Kotz, 2007).

Additionally, other factors may account for depressive symptoms. For instance, depressive symptoms are common in patients with Generalised Anxiety Disorder (GAD) (Freeman, Prertzer, Fleming, & Simon, 2004; Restifo, 2009; Sadock & Sadock, 2007). Furthermore, stress and depression have been reported as being correlated by many researchers (e.g. Brown & Harris, 1989; Hammen, 2005; Pizzagalli, Bogdan, Ratner, & Jahn, 2007). Research has found that depressive symptoms can be induced by stress (Lloyd, 1980; Kendler, Karkowski, & Prescott, 1999) and that more frequent relapse and poorer treatment outcome of depression is associated with stress (Tennant, 2002). Therefore, to effectively treat depression the context is critical.

In order to gain a more grounded understanding of depression qualitative studies are required to access an insight into depression from an individual's perspective. There is a paucity of this type of study in the literature. Ethical debates continue regarding qualitative research, particularly with vulnerable populations such as those with a mental illness (Moyle, 2002). This is usually in relation to informed consent. In addition, Moyle (2002) noted the difficulty of interviewing participants with a mental illness. Using unstructured interviews with participants hospitalized for clinical depression, she found that they had difficulty describing their experience, staying on task, remembering events and remembering the questions asked in the interview which affected the richness of her data. This implies that it could be of more value to interview participants who are no longer depressed and who can reflect back on a time in their lives when they considered that they were depressed, thus constructing an individual's experience of his or her depression over time. Parker, Georgaca, Harper, McLaughlin, and Stowell-Smith (1995) point out that depression is socially constructed and these constructions change over time and context.

With depression on the increase in New Zealand and New Zealand having relatively high rates compared to world figures, it is imperative that researchers work to build a literature base within the New Zealand context. This will enable practitioners to expand on their current understanding of depression gleaned from other cultures and aid best treatment practice for New Zealanders. Furthermore, it facilitates comparisons across a broader range of countries.

The Present Study

The current study explored factors relating to the context and course of depression from the perspective of previously depressed adults living in New Zealand. A number of quantitative studies conducted in other countries have explored factors associated with depression (e.g. Laurence, Williams & Eiland, 2009; Mazza et al., 2009; Sandi & Richter-Levin, 2009; Sigfusdottir & Silver, 2009). However, the experiences of the participants were not explored.

There have been fewer qualitative studies published in this field. Again, those that have been researched within other cultures (e.g. Fu & Parahoo, 2009; Lawrence et al., 2006).

Therefore, the reflections and inferences on the experiences of 13 participants involved in this final phase of study of a group of previously depressed adults formed the focus of this research.

Thesis Overview

The thesis comprises 12 chapters. The first chapter includes the introduction and rationale for the current research. The literature review comprises chapters 2 to 6. Chapter 2 encompasses recent research pertaining to depression. The third chapter explores other qualitative studies of depressed individuals completed overseas. The fourth chapter reviews perceived stress which was the most common finding from other qualitative research. Chapters 5 and 6 review attachment and early trauma respectively as questions in the interview and Personal History Questionnaire – Final Phase (PHQ-F) covered aspects of early parenting as well as first memories and traumatic events.

Chapter 7 comprises the methodology for the study. This includes the rationale for the choice of method, relevant information pertaining to the previous intervention trials, and the qualitative methodology employed.

Findings and discussion are covered in Chapters 8 through to 11. Discussion integrates current literature with emerging theories, highlights areas for further research, and discusses implications for conceptualization of depression and clinical practice. Finally, the limitations and conclusion are conveyed in Chapter 12.

The initial findings were presented at the New Zealand Psychological Society Annual Conference in July, 2010 (See Appendix F).

Literature Review

Chapter 2

Depression

Depression has been described as a prison where the individual is both the prisoner and the jailer (Rowe, 2003). It is differentiated from unhappiness by the ability when unhappy to accept sympathy and loving concern and gain comfort from this. With depression, on the other hand, the capacity to respond to sympathy and loving concern is diminished.

Prevalence rates tend to increase with age. Josephson (2007) notes an increase in prevalence from pre-pubertal children to adolescents, and Lewinsohn and Clarke (1999) report a slightly higher prevalence in adults than in adolescents. Whilst prevalence decreases again in the elderly (Kaelber et al., 1995; Oakley-Browne, 2006), depression is the psychiatric disorder most commonly diagnosed in older people (Koder, Brodaty, & Anstey, 1996).

Women are reported to experience a higher rate of depression than men by approximately 2:1 (Kaelber et al., 1995; Oakley-Browne, 2006; Sadock & Sadock, 2007), implicating gender as a risk factor. These findings were replicated in the New Zealand Mental Health Survey (NZMHS) (Oakley-Browne, 2006) with men having a lifetime prevalence rate of 11.4 and women 20.3. Various reasons for this difference have been hypothesized and include: hormonal differences, the behavioural theory of learned helplessness, changes due to childbirth, and psychosocial stressors varying between men and women (Sadock & Sadock, 2007). Further explanations are that women may self-report more frequently and openly than men (Kessler, McGonagle, Swartz, Blazer, & Nelson, 1993), and that men may deal with depressive symptoms by the use of behaviours that are more prevalent in men than women such as antisocial behaviour and substance abuse. Another possibility is that women may feel devalued owing to long-standing societal bias (Kaelber et al., 1995). Sigmon et al. (2005) suggested

that each gender has differing prototypical emotions; anxiety and depression for women and anger and pride for men. Additionally, medicalisation, and therefore pathologising, of women's natural psychological and physical functions was further purported by the feminist movement to influence higher help-seeking behaviour of women (Nazroo, 2001).

Younger people (ages 14-16) with depression are at greater risk of developing poor psychosocial outcomes such as unemployment, underachievement, and early parenthood by young adulthood (ages 16-21) (Fergusson & Woodward, 2002). Furthermore, early depression is directly linked to an increased risk of major depression and anxiety disorders at a later stage. Depression can develop at even earlier ages. Figures from a sub-sample of 641 children from the Dunedin Multidisciplinary Health and Development Study (DMHDS), born in Dunedin in 1972 and 1973, estimate the prevalence of major depressive disorder in nine-year-olds to be 1.8% (Tripp, 2007).

There have been a number of theories of depression developed over the years such as physiological/biochemical, learned theories, and cognitive theories. Biomedical models imply that depression is caused by low levels of neurotransmitters in the brain, in particular Norepinephrine (Sadock & Sadock, 2007). It was observed that tricyclic drugs and monoamine oxidase inhibitors (MAOIs) improved symptoms of depression. Therefore, it was surmised that defective neurotransmitters were the cause of depression. However, it is still unclear as to what part they play.

Psychosocial models of depression took hold, including attachment theory and learning theory. One such learning theory is Martin Seligman's learned helplessness model of depression (Sadock & Sadock, 2007). This was developed through experimenting with classical conditioning in dogs. Dogs were given electric shocks and restrained from avoiding them. It was noted that they eventually gave up, hence learned helplessness. This theory was transferred to humans and depression. For example, children who are continually told they are useless and dumb will give up trying and believe it to be true.

In more recent times, Beck's (1976) cognitive model of depression was developed, incorporating therapeutic techniques. Beck proposed that cognitive errors, schemata, and automatic thoughts are central to the development of depression. Such cognitive errors cause an individual to view the world, themselves, and the future in a negative manner, known as the cognitive triad. Beck proposed that such thinking can be reconstructed to a more balanced and healthy style of thinking, hence reducing depressive symptoms.

Such high prevalence rates of depression across all age groups suggest an urgent need to gain a deeper understanding of depression including associated factors such as environmental influences from early childhood. Previous theories and models of depression have been helpful in gaining some insight into this disorder. However, lacking is research on depression from the perspective of individuals who have experienced it. Such research could gain useful knowledge and understanding which could be incorporated into the development of a social/contextual model of depression. Such a model may shape suggested treatment as well as prevention measures. Perspectives from individuals who have previously been depressed would add valuable knowledge to the current literature.

Chapter 3

Qualitative Studies to Date

Qualitative studies in the literature on depression are scant and to date a comprehensive search has found none conducted in New Zealand. A recent qualitative study conducted among Taiwanese people recovering from depression post hospitalization explored their perceptions of the causes (Fu & Parahoo, 2009). The main causes perceived by this group of people were social and cultural in origin. Specifically, stress in marital relationships, conflict in extended families, changes in life circumstances, and early life experiences were identified as the main themes. Regarding stress in marital relationships, cultural beliefs appeared to be the principal cause. For women, the traditional dominant husband left women feeling like servants in the home while their husbands conducted extra marital affairs, leaving the relationship feeling emotionally empty. For men, some found that wives who had moved away from tradition and worked outside the home threatened their manhood. Their traditional role was being eroded and they felt that their wives were behaving like men. Conflict within extended families appeared to be culturally related. Men in particular found the expectations of equal treatment and support for both his parents and his wife particularly stressful. The implications from this study for health care providers in Taiwan is that treating these individuals for depression without considering and treating the causes is likely to result in relapse. Participants in this study had been hospitalized for depression. It is possible, therefore, that factors relating to hospitalization such as knowledge of depression gained by contact with healthcare professionals influenced their perceptions.

A cross-cultural qualitative study in the United Kingdom (UK) identified stress as a leading cause of depression, with loss being the primary cause across all ethnic groups studied (white British, South Asian, and Black Caribbean) (Lawrence et al., 2006). The study reported on the beliefs of older adults, recruited from primary care practices, about the meaning of the word depression,

and the causes. Again, contact with primary care professionals might influence perceptions. Furthermore, being an older population it could be argued that loss is more likely. Regardless, Lawrence et al. (2006) revealed that social issues and adverse personal circumstances dominated the explanations. Depression held different meanings between cultures and social issues varied across cultures indicating that a social model of depression was more appropriate for this elderly population than the traditional medical model. A further study using survey techniques with 66 college students in America, although inconclusive as to the aetiology of depression, also suggested the current emphasis on the medical model of depression be viewed with caution (Goldstein & Roselli, 2003).

Granek (2006) agreed that the medical model of depression and use of the DSM-IV for diagnosis without considering context is inadequate and lacks the deeper understanding required for adequate treatment of this condition. She held that it is necessary to study depression experientially, that is, through qualitative methods in order to ascertain the context and lived experience of the person feeling the distress. She used a convenience sample in her Canadian study of six graduate students (ages 25-30) who were not depressed at the time of the study according to the Clinical Structured Interviews Diagnosis (SCID). They had apparently suffered a depressive episode in the last year although it was not clear how this was determined. She found that depression for this group of people was embedded in relationships. For five participants it was the loss of a long-term romantic relationship and for the sixth participant the result of a break from her parents. The subsequent feelings of loss, loneliness and rejection resulted in self-criticism and a sense of disconnection triggering depressive symptoms. Further findings highlighted the anxiety this group of people felt. This was described as a discomfort being around other people, being anxious and agitated in public, feeling a knot in the stomach, nervousness, and anger. Anger was paramount in this group as a large contributor to their experience of depression.

A more recent study of black women in Canada, while investigating midlife health for this group, discovered depression was a key finding (Etowa, Keddy, Egbeyemi, & Eghan, 2007). A purposive sample of women who did not have to

be depressed to be included in the study were interviewed and asked to complete the Center for Epidemiologic Studies Depression (CES-D). Additionally, community workshops were run by the women enabling them to be more involved in the research process. One year later focus groups were held which included men and youths. Regardless that such a long process of involvement with researchers might influence depressed individuals, Etowa et al. (2007) discovered depression to be associated with a myriad of triggers with many unable to articulate a cause. The dominant findings were: concerns for their children and families; stress related to loss, grief and death; racism; menopause; and anxiety and pain related to illness. For this group of women depression appeared to occur in a social context with multiple roles culminating in stress.

In 2008, a qualitative study was undertaken in an endeavour to understand depression among a small sample of Mexican immigrant men in the United States of America (Lackey, 2008). As with the previously mentioned studies, this researcher found context to be paramount with causes described as being predominantly psychosocial in nature according to six out of the seven focus groups. Three main 'depressed affect symptoms' were highlighted across all focus groups: sadness; constant worrying; and thinking too much (p. 232). Almost every participant mentioned separation from loved ones as being a cause of their depression. Additionally, long working hours with little relaxation time was discussed as a trigger. For some however, the lack of work or receiving poor income caused depressive symptoms as they were unable to provide finances for their family back home. In accordance with Lawrence et al., (2006), Goldstein and Roselli (2003), and Granek (2006), Lackey (2008) found the medical model of depression insufficient to help these individuals. In fact, there was an apparent anti-medication discourse. Help for this group was found within family, the community, or a professional working in the psychosocial field.

In contrast, a study of women living in Asian communities in the UK discovered that these women tended to somatise their depressive symptoms in order to access medical expertise (Burr & Chapman, 2004). Burr and Chapman (2004) infer that this was not in passive acceptance of the medical model of

practice. Rather, they felt that physical complaints were taken more seriously and opened access to a wider range of help. However, this study was limited to English speaking women who were mostly born in the UK and, therefore, were likely surrounded by Western culture and understanding of individuals and the concept of depression. Regardless, the implications for clinical practice with this group of women are that their emotional health might not be discussed in terms of 'feelings', but rather physical complaints.

A further immigrant-based study reported on findings of Irish immigrants to the UK. Leavey, Rozmovits, Ryan, and King (2007) recruited 25 participants from general practices in the north of London where Irish populations are widespread. They found that, for many of the participants their distress was related to happenings in their home country or difficult life events. Migration per se was not seen as a negative life experience. Leavey et al. (2007) recognised the difficulty of representing an immigrant population and acknowledged that these findings were not necessarily representative of all Irish immigrants to the UK or elsewhere.

In South Africa the emotional health of 10 depressed individuals was ascertained from a narrative perspective. It is not known if these individuals were clinically depressed as they were volunteers from the local university and churches who perceived themselves as struggling with depression. Findings showed that depression for this group appeared to be associated with the negative meanings that they attached to their life experiences (Robertson, Venter, & Botha, 2005). They commonly used negative language and generalizations in telling their stories. This included talk of what their future experience might entail. For example, "my future story is rotten" and "I worry about the future" (p. 338). As well as negative connotations, this group's story of depression was embedded in socio-political contexts.

Summary

Reviewing qualitative studies in other cultures revealed stress to be the predominant cause of depression, endorsing a social model of depression as more

appropriate than the medical model of depression which is currently widely utilized and accepted. From the depressed individual's perspective, the majority of stressors involved social, political, and cultural issues. Negative meanings of life experiences were emphasised in the narrative exploration. Relationships were problematic across cultures.

Stress from relationships was the cause for the group of Canadian students (Granek, 2006), with symptoms of social anxiety, nervousness, and anger being most widely described. Symptoms of anxiety were also present in the Mexican immigrant men in the US (Lackey, 2008), with constant worrying and thinking too much commonly discussed. However, in both studies all symptoms were related to and discussed in terms of depression.

With the exception of the Canadian students who were described as previously depressed, although unclear as to how this information was ascertained, participants in the studies discussed above appeared to be currently depressed, with recruitment being via hospital or primary care settings. The difficulty with hospitalised individuals has been described in my introduction. Briefly, these were difficulties describing events, staying on task, and problems with memory. Additionally, there is the likely influence of professionals working within the medical model of depression on individuals' perceptions.

Burr and Chapman's (2004) study highlighted the command the medical model has on society for all illnesses, whether physical or psychological. The Asian women in the UK who somatised their depressive symptoms in order to be taken seriously, and to gain access to a wider range of help, possibly at the expense of their emotional health, indicates how society has the power to shape individual perceptions and decisions.

However, the anti-medication discourse described in Lackey's (2008) study implied that not all minority cultural groups were influenced by the medical model as they rejected it for preferred help within family, the community, or a professional working in the psychosocial field.

The above studies highlight the different meanings of depression between cultures and how social issues vary across cultures. All were conducted within

other cultures and within countries outside of New Zealand, hence the importance of a qualitative study developed and conducted in New Zealand to enhance depression research within this culture and social context.

Chapter 4

Stress

Stress and social issues were strongly correlated with depression in previous qualitative studies. Therefore, it seemed relevant to include stress theory in the literature review.

Stress Theory

Stress has been defined as “any real or imagined event, condition, situation, or stimulus that instigates the onset of the human stress response process within an individual” (Matthieu & Ivanoff, 2006, p. 340). There have been a number of theories of stress proposed over the years beginning with a physiological theory as described by Selye (1957). Further linear theories were proposed such as stress as a stimulus (stimulus from the environment) and stress as a response (responses of the individual) (Derogatis, 1982). One theory which continues to be quoted today is Lazarus’ theory of stress which has been described as a “cognitive-phenomenological theory” (Folkman, Lazarus, Dunkel-Schetter, DeLongis & Gruen, 1986, p. 992). This is a transactional model, meaning that stress is not viewed as linear but as bi-directional and that stress is the product of interactions between the person and the environment with mediating processes (e.g. appraisal and coping) that influence short and long term outcomes (Folkman et al., 1986). According to Lazarus’ theory, after a stressful event an individual evaluates the situation. Lazarus called this the ‘primary appraisal’. From this first appraisal the individual will either regard the event as not stressful and requiring no action or stressful after which a ‘secondary appraisal’ takes place. This secondary appraisal involves the individual evaluating their coping resources within their context (Radnitz & Tiersky, 2007). Once a coping strategy has been chosen and employed, these appraisals can continue altering the emotional response and the subsequent coping strategies employed.

Stress is a perceived phenomenon. Perceived stress has been discussed in terms of the degree to which an individual views his or her life as being

uncontrollable, unpredictable, and overloading (Cohen, Kamarek, & Mermelstein, 1983). Cohen et al. (1983) report that the experience of stress has repeatedly found these three issues to be core components. The higher the level of perceived stress the more an individual is vulnerable to psychological distress including depression.

Coping in Stress Theory

Coping is a continuation of stress theory and has been defined as an interaction of cognitive processes and behavioural patterns which are constantly changing and employed to manage external and internal stimuli that an individual appraises as difficult or stressful (Lazarus & Folkman, 1984). This includes all efforts regardless of their effectiveness and outcome. Lazarus (1999) describes two widely recognised functions of coping: emotion-focused and problem-focused. In emotion-focused coping, an individual will attempt to regulate their emotions with regard to a stressful situation by coping strategies such as avoiding thinking about the stressor or reappraising the stressor without actually changing it. Problem-focused coping endeavours to utilise resources and behaviour with the purpose of addressing and altering the external environment-individual relationship. This can mean strategies aimed towards the individual or the environment.

Stress and coping theories are helpful and necessary in current practice in order to be able to guide a client through the cognitive processes of a difficult life stressor (Matthieu & Ivanoff, 2006).

Stress and Depression

The relationship between stress and depression has been reported as being correlated by many researchers (e.g. Brown & Harris, 1989; Hammen, 2005; Pizzagalli et al., 2007). Research has found that depressive symptoms can be induced by stress (Lloyd, 1980; Kendler et al., 1999) and that more frequent relapse and poorer treatment outcome of depression is associated with stress (Tennant, 2002). Most studies of stress and depression have focused on stressful life events as triggers (Cohen, Janicki-Deverts & Miller, 2007). However,

increased stress rather than a specific event also provokes the onset and predicts the clinical course of major depression for individuals (Hammen, 2005; Mazure, 1998).

Stress impacts on individuals in various ways, therefore how individuals perceive stress is likely to affect their mood. A person who perceives stress as unpredictable, uncontrollable, and overloading has an increased chance of having a depressive episode than those who do not perceive stress in this manner (Hammen, 2005; Pizzagalli et al., 2007). In particular, uncontrollability of stressors has been found to have a significant impact on emotional disorders (Chorpita & Barlow, 1998). Willner, Wilkes and Orwin (1990) noted that individuals with melancholic depression do not report higher numbers of minor daily stressors. However, they report higher levels of subjective severity than individuals without melancholic depression. Pizzagalli et al.'s (2007) results indicate that individuals with a familial history of depression are more vulnerable to hedonic symptoms and negative affect when under a higher level of perceived stress.

Coping and Depression

Some research acknowledges that individuals using problem-focused coping are less at risk of psychological problems than those who employ emotion-focused techniques (e.g. Kort-Butler, 2009; Nagase et al., 2009). More specifically, avoidant coping styles have been found to place individuals at most risk of developing psychological problems (Lewis & Frydenberg, 2004). Furthermore, gender differences have been implicated. Girls have been found to score higher than boys on avoidant coping techniques and depressed mood (De Boo & Spiering, 2010). For both genders, negative affectivity predicted aggression and depressed mood, with coping not being involved. Frydenberg and Lewis (2009) also found that girls who used more avoidant coping suffered greater distress than those using active or problem-focused coping.

Other research deviates from the above findings. In a study of Turkish adolescents, Ongen (2006) found that low use of either coping strategy was

predictive of higher depressive symptoms. On the other hand, individuals who used high levels of either coping style, including avoidant coping, reported less depressive symptoms.

Current research on coping styles and depression brings an awareness of the importance of culture with regard to the different styles of coping. In 2007, Mosher and Prelow discovered that avoidant coping was related to better coping and, therefore, less depressive symptoms for African Americans. On the other hand, there was no significant relationship between avoidant coping and coping efficacy for European Americans. Similarly, a study involving Chinese patients with Type II diabetes suggested that an 'active coping style' produced fewer symptoms of depression and anxiety (Zhang, Tse, Yet, Lint, Chen, & Chen, 2009). However, there was a variance in emotion-focused coping. They found that a 'negative coping style' was associated with depressive and anxiety symptoms but 'avoidance coping' was negatively associated with depressive symptoms.

Summary

Stress is currently viewed as bi-directional and is the product of interactions between an individual and the environment. It is a perceived phenomenon with core components identified as to how much an individual perceives a situation to be uncontrollable, unpredictable, and overloading. Higher levels of perceived stress equate to higher levels of psychological distress, including depression.

Coping has been described as an interaction of cognitive processes and behavioural patterns in response to stressful situations. This includes helpful and unhelpful coping strategies. Two types of coping are commonly discussed: emotion-focused and problem-focused. Emotion-focused attempts to minimize the discomfort felt from emotions without changing the stressor. Avoidance is the most commonly employed emotion-focused strategy. Problem-focused attempts to alter the relationship between the individual and the environment.

Research indicates that stress and depression are correlated. Depressive symptoms have been shown to have been induced by stress, and stress is related to poorer treatment outcomes and more frequent relapses. How stress is perceived

determines the psychological outcome, and increased stress, as well as specific stressors, are associated with depression.

Contradictory research regarding coping and depression might indicate cultural differences. For some cultures emotion-focused coping was detrimental to psychological health. However, for other cultures it was not. More often than not, problem-focused coping resulted in less psychological distress than emotion-focused coping. An avoidant coping style appeared to cause most of the distress.

Chapter 5

Attachment and Bonding

Definitions

The terms *attachment* and *bonding* are more often than not used synonymously. However, according to Sadock and Sadock (2007), they are different phenomena.

Attachment is defined by Sadock and Sadock (2007) as “the emotional tone between infants and their caregivers” (p. 138). This is demonstrated by the infant seeking and clinging to its primary caregiver, usually the mother, and can typically be evidenced within the first month of the infant’s life. Attachment styles may then continue into adult life, expanding the definition from infants to an enduring affective bond which is characterized by a tendency to seek and maintain proximity to a specific figure, particularly when under stress (Carver & Scheier, 2004).

Bonding is more concerned with the caregiver’s feelings towards the infant, which generally does not involve the ‘need’ for the caregiver’s secure attachment to the infant as is typical of attachment behaviour.

For the purposes of this study, attachment rather than bonding is the phenomenon being explored.

Development of Attachment Theory

Attachment theory owes its beginnings and development from the 1950s through to the 1980s to John Bowlby, the English psychiatrist and psychoanalyst (Miller, 2001). Bowlby, even before his career as a psychiatrist began, “was alerted to a possible connection between prolonged deprivation and the development of a personality apparently incapable of making affectional bonds and, because immune to praise and blame, prone to repeated delinquencies” (Stroebe, 2002, p.129). This realization occurred while working in a school for maladjusted children prior to completing his clinical training (Bowlby 1981). Having come from an upper-middle class family with a disciplinarian mother who favoured

strict routines and a father who was remote, and having been sent to boarding school at the age of seven, he found that he could relate to these children and proposed that their difficulties stemmed from an unhappy childhood. With his clinical and child analysis training complete, Bowlby embarked on the gathering of emotional data, the first of this kind (MacDonald, 2001), and so the development of attachment theory began.

From the study of ethology (Harlow's (1958) rhesus monkeys study and Lorenz's (1935) gosling study (MacDonald, 2001)), both of which highlighted the importance of the mother/infant bond in animals, Bowlby recognised the significance of the mother/infant bond and the impact on an infant or child of what he coined "maternal deprivation".

Attachment Theory

Bowlby (1982; 1988) argued that the mother/infant attachment was of utmost importance in terms of being able to develop important relationships later in life. The child forms mental representations of its secure base experience and these representations affect later development (Waters, Corcoran, & Anafarta, 2005). Problems arising from poor attachment include anxiety and depression as well as the inability to be a successful parent themselves in adulthood (Rikhye et al., 2008; Stroebe, 2002).

Various models of attachment have been presented. Results of a study by Ainsworth, Blehar, Waters, and Walls (1978) revealed three styles of attachment: *securely attached*, *insecure (anxious/ambivalent)*, and *insecure (anxious/avoidant)*. A fourth style was identified by Main and Solomon (1990) as *disorganized/disoriented*. Securely attached is the optimum relationship in which the infant might be slightly upset when the mother leaves and will reach out for her on her return. An anxious/ambivalent child will be extremely upset when the mother departs and will display anger and defiance on her return, while an anxious/avoidant child will be indifferent to the mother leaving and will ignore her return. Children with a disorganized/disoriented style of attachment

commonly fit maltreated children (Carlson, Cicchetti, Barnett, & Braunwald, 1989) and display signs of fear towards their caregiver.

According to some researchers (e.g. Diamond, Diamond, & Hogue, 2007; McBride, Atkinson, Quilty, & Bagby, 2006), it is common for attachment styles to be classed as two dimensional: that of anxious ambivalent and anxious avoidant.

Main and Goldwyn (1998, as cited in Riggs & Jacobvitz, 2002) proposed adult parallels of these attachment styles by means of the Adult Attachment Interview (AAI). The AAI is an in-depth interview undertaken with adults gleaning information regarding their perspective of their relationship with each parent as they were growing up including aspects such as how their parents dealt with adverse situations, how they dealt with separations, and how their childhood experiences might have influenced the development of their adult personality. The four adult attachment styles described as *secure*, *dismissing*, *preoccupied*, and *unresolved* essentially correspond respectively to the *secure*, *avoidant*, *ambivalent* and *disorganized* childhood attachment characteristics discussed above. An adult is considered secure if they are able to talk openly about their childhood relationships with their parents, including adverse events such as trauma and/or abuse (Riggs & Jacobvitz, 2002). Children who have suffered negative experiences as a child can become secure adults. According to Riggs and Jacobvitz (2002), both dismissing and preoccupied adults are less comfortable about discussing their relationship with their parents during childhood and actively avoid doing so in order to avoid the distress they tend to feel. Dismissing adults have a propensity to either refuse to answer questions concerning their parents or they put their parents on a pedestal. Preoccupied adults are more inclined to appear anxious, talking excessively often losing sight of the original topic. Additionally, they might appear angry and blaming towards their parents for current problematic relationships. Dismissing adults are prone to externalizing psychopathology while preoccupied adults are associated with internalizing disorders including anxiety and depression (Cole-Detke & Kobak, 1996). An unresolved adult attachment characteristic is observed when adults are unable to

discuss childhood trauma without adverse psychological reactions such as momentarily appearing to be in a trance-like state mid sentence or briefly being disoriented (Riggs & Jacobvitz, 2002). Riggs and Jacobvitz (2002) found that adults with an unresolved attachment orientation were more inclined to have higher reports of suicidal ideation and psychological distress. Adults with unresolved trauma were more inclined to report a history of drug or alcohol abuse, while adults with unresolved loss reported more criminal charges.

From a review of the attachment literature, Parker, Tupling, and Brown (1979) identified two key parental characteristics that impact on the bond between parent and child. These are care and psychological control or overprotection. In order to measure these two characteristics Parker et al. (1979) developed the Parental Bonding Instrument (PBI), a self report instrument measuring how adults remember their parents during their first 16 years. The PBI has four quadrants which reflect combinations of these two characteristics. The quadrant reflecting ideal parenting is *optimal parenting* which means high care and not being overprotected (i.e. low protection). The quadrant *affectionate constraint* reflects high care and a tendency to be overprotective or controlling (i.e. high protection). *Affectionless control* reflects high protection and low care, and *neglectful parenting* reflects both low care and low protection. Whilst the PBI measures attachment styles it does not directly assess attachment behaviour (Anvin, 2004; Gittleman, Klein, Smider, & Essex, 1998; Manassis, Owens, Adam, West, & Sheldon-Keller, 1999).

Attachment and Psychopathology

In adults, maladaptive patterns developed as a result of attachment issues in childhood commonly lead to psychopathology (Diamond et al., 2007; Liu, 2006; Oakley-Browne, Joyce, Wells, Bushnell, & Hornblow, 1995; Rikhye et al., 2008; Sadock & Sadock, 2007). Sadock and Sadock (2007) include as disorders of attachment: “failure-to-thrive syndromes, psychosocial dwarfism, separation anxiety disorder, avoidant personality disorder, depressive disorders, delinquency, academic problems, and borderline intelligence” (p. 140). Ehnvall, Parker, Hadzi-

Pavlovic, & Malhi (2008) discuss rejection sensitivity in adults as possibly being linked to perceptions of childhood rejection. McBride et al. (2006) discuss an association between anxiety and obsessive symptoms and attachment. Kraaij et al. (2003) and Matheson, Kelly, Cole, Tannebaum and Anisman (2005) relate poor parental/infant attachment to the development of inappropriate coping skills which results in individuals being susceptible to stress and depression.

Attachment and Depression

It is clear from the majority of research on attachment theory and associated disorders that poor attachments or attachment insecurity commonly leads to depression (e.g. Lancaster, Rollinson, & Hill, 2007; Liu, 2006; McBride et al., 2006; Oakley-Browne et al., 1995; Rikhye et al., 2008; Wei & Ku, 2007). More specifically, low care/high protection (affectionless control) style of parenting has been linked to neurotic depression but not to endogenous depression (Parker, 1979; Rikhye et al., 2008). Parker (1979) found that neurotic depressives' perception of their childhood parenting experience was that of less care and greater maternal over protection. In a non-clinical group, low parental care was reported but there was only a weak association with overprotection.

The terms 'neurotic depression' and 'endogenous depression' are not readily used today and are not in the DSM-IV. Neurotic depression refers to a chronic or recurrent set of symptoms without psychotic features mainly characterized by features of anxiety (Sadock & Sadock, 2007). Endogenous depression has been described as depression from within which is not necessarily precipitated by an external stressor (Kiloh & Garside, 1963).

Other research offers mixed results. In a community survey of 386 individuals by McKinnon, Henderson, Scott, and Duncan (1989), the only association found between attachment (PBI) and psychiatric disorders was that of low maternal care being associated with depression in females. In their 1993 study, McKinnon, Henderson, and Andrews found that the primary risk factor for depression was lack of care rather than overprotection with no interaction effect

between the two. This analysis came from a sample of 922 twins aged 18-65 years.

Kerver, Van Son, and de Groot (1992) also found an association with low parental care, specifically paternal care, and depression. However, no predictive value was found. This study, however, was telephone based with only 212 participants responding out of the 1000 approached. This may render the study subject to 'volunteer' bias. However, Parker and Manicavasagar (1986) found a paternal association with depression. In their study of adult depression being associated with childhood bereavements, they found that the most consistent predictor of depression was the existence of a lower paternal social class. Again, bias needs to be considered as this was a study of 79 women who lost their mother in childhood and whose father had remarried. They found no interaction between lower paternal social class, style of parenting as measured by the PBI, and depression.

More recently, Liu's (2006) research with 1,144 eighth-graders found that both paternal and maternal attachment significantly predicted depressive symptoms in adolescents.

Another sample of women only, aged 18-44 years found only a weak association between all types of parental loss (including death, separation, divorce etc.) and lifetime major depression (Oakley-Browne et al., 1995).

Exposure to early life stress (mainly maltreatment rather than loss) was noted as a possible cause of adult depressive symptoms in a sample of 72 adults who reported childhood maltreatment and 69 adults who did not report such maltreatment (Rikhye et al., 2008). This study contradicts the majority of studies citing maternal care as most important by finding a small but significant association between care and quality of life and paternal care but maternal care had no association.

Using a conceptual model of self-defeating patterns and psychological distress, bearing in mind that self-defeating patterns have been found to be positively associated with depression (Lester & Hoffman, 1992), Wei and Ku

(2007) reported an association between adult attachment and distress, and that self-defeating patterns were a mediator between the two.

Clearly most research has found some form of positive association between attachment styles and psychological distress. Sadock and Sadock (2007) note that Bowlby initially felt that damage from attachment issues due to parent/child separation was permanent. However, he learned that change was possible depending on when the separation occurred, what type of separation it was, whether it was long-lasting, and how secure the relationship was prior to separation. In their research of attachment as a moderator of treatment outcome in major depression, trialing interpersonal psychotherapy and cognitive behaviour therapy (CBT) McBride et al. (2006) found that attachment anxiety was more readily changed. However, attachment avoidance was a more permanent condition less likely to alter.

Summary

Attachment theory emerged in the 1950s, developed by John Bowlby. He proposed that the mother/infant relationship was most important for developing successful relationships later in life. Problems of poor attachment include anxiety, depression, and the inability to parent successfully.

Four styles of attachment have been identified: securely attached; insecure (anxious/ambivalent); insecure (anxious/avoidant); and disorganized/disoriented. Some researchers consider only two dimensions, that of anxious/ambivalent and anxious/avoidant.

Adult parallels of the four attachment styles can be assessed with the AAI, an interview designed to glean adult perspectives of their relationship with each parent. The four equivalent styles include secure, dismissing, preoccupied, and unresolved. Securely attached individuals will talk openly and comfortably about their relationship with either parent, whereas, dismissing and preoccupied individuals are less inclined to talk. Dismissing adults will either refuse to answer questions or put their parents on a pedestal. Preoccupied individuals tend to be anxious, talk excessively, and lose sight of the original topic. Unresolved

attachment styles leave individuals unable to talk about their childhood trauma without obvious psychological distress, have higher suicidal tendencies, and are more inclined to have drug and alcohol problems.

The finding of two key parental characteristics prompted the development of the PBI, a self-report questionnaire for adults, again gleaning the adult perspective of how they were parented as a child. The PBI measures four combinations of care and psychological control (overprotection), the two key characteristics.

Attachment issues in childhood are consistently correlated to adult psychopathology, including depression. Research is inconclusive as to which parent, if any, holds more importance as some research confirms the mother/child relationship while other research has found the father/child relationship to be more important.

Chapter 6

Early Trauma

Associated with attachment issues and depression is trauma. The relationship between trauma and psychopathology was first recognised over one hundred years ago by Pierre Janet who observed that the type of response to an event elicited from an individual was dependent upon the person's state and their cognitive interpretation of the situation (van der Kolk, van der Hart, & Marmar, 1996). Horrific events are common to mankind and trauma is the result of a person's adaptation to such events (Williams, 2006). Some people are able to develop a resiliency to traumatic events while others find themselves unable to function at their baseline level in the face of trauma.

Trauma can be caused by numerous events and actions. Included is family violence, including physical and emotional abuse and neglect, bullying, loss, and injury and illness. Childhood trauma is recognised as a risk factor for depression (Dopheide, 2006).

Abuse

The simple act of smacking a child, currently a very controversial form of discipline, has many established negative effects which include increased aggression, the association of love and pain which can have implications in adult relationships, the generation of anxiety, negative emotional side effects including depression, and interference in attachment between the child and their caregiver (Ritchie, 2007). Although smacking is not generally considered to be abuse, many children suffer constant abuse often under the guise of discipline. Whilst trauma in adults which includes abuse might damage the adult formed personality, such trauma in children has the ability to deform a child's personality (Herman, 1992). Yet humans have an inherent need to attach regardless of the behaviour of the attachment figure (Williams, 2006). Loss of such an attachment figure in children and adults alike, results in the search for a replacement attachment figure, 'any' attachment figure.

Abuse and Depression

These insecure patterns of attachment lead to problems regulating affect. Major depression in particular is correlated to family history (Rice, Harold, & Thapar, 2002). Genetic components have been tenuously argued with no conclusive evidence (Caspi et al., 2003; Rice et al., 2002), while behavioural patterns within families and high parental psychopathology are purported to be the biggest significant risk factor (Weller, Weller, Fristad, & Bawa, 2001).

Sexual assault and/or abuse histories have been linked with long-lasting emotional and behavioural difficulties. Green et al. (2005) found that a history of sexual or physical abuse led to the individual engaging in risky sexual and other destructive behaviours, with major depression and posttraumatic stress disorder (PTSD) being associated with many of the behaviours. Ongoing assault caused a higher rate of these behaviours and associated disorders. However, it was found that one off abuse was sufficient for some risky behaviours. Cohen, Mannarino, Murray, and Igelman (2006), from their review of randomised controlled studies, agree that child sexual, physical, and emotional abuse, as well as neglect and domestic violence leads to significant emotional and behavioural issues.

Compared to physical and sexual abuse, emotional maltreatment in children had a higher association with self-reported negative associations and a higher risk of developing depression or anxiety disorders according to van Harmelen et al., (2010). Furthermore, Liu, Alloy, Abraham, Lacoviello, and Whitehouse (2009) found that emotional maltreatment predicted an earlier onset of depression in young adults, in particular 'hopelessness depression'.

Not only is being a victim of violence positively associated with depression and anxiety, but simply witnessing violence is positively associated with both of these disorders. Victimization is also positively associated with conduct disorder, as was found in the above-mentioned studies. However, being a witness only was not (Ward, Martin, & Distiller, 2007).

Bullying

Bullying can be defined as a form of aggression where one or more children intentionally harm or disturb another child who is perceived as being weaker and unable to defend him or herself (Glew, Rivara, & Feudtner, 2000). It implies an imbalance of power with the bully generally being more powerful, either physically or psychologically (Gervay, 2007; Nansel et al., 2001). Bullying behaviours include threatening, name calling, stealing, slandering, taunting, excluding, vandalizing, and physical assault, (Beale, 2001) and tend to be repetitive (Nansel et al., 2001).

Bullies are commonly divided into four categories: physical, verbal, relational, and reactive (Beale, 2001). Physical bullies are the easiest to identify using visible techniques such as kicking and punching. These bullies are more commonly boys and over time can become more aggressive, taking this aggression into adulthood. Verbal bullies are less easily identified, using words to hurt their victim. While there are no physical signs in the victim of this type of bullying, psychological outfall can be devastating and long-lasting. Relational bullies, most often girls, attempt to increase their power by persuading friends to exclude certain children. The subsequent feeling of rejection in the victim can lead to negative psychological outcomes, particularly as social connection is critical throughout this time in their lives (Crick & Grotpeter, 1995). Reactive bullies tend to taunt their victim into fighting with them, fight back, and then claim self defense. They are inclined to be impulsive and can again be difficult to identify (Smokowski & Kopasz, 2005).

Bullying is widespread in schools. It is reported to be the most common form of violence within schools with approximately 30% of children in grades 6-10 (US) involved to some degree, either as the bully or as the victim, or both (Fight Crime: Invest in Kids, 2003). Children themselves consider bullying to be more problematic than drugs or alcohol, pressure to have sex, AIDS, or racism (Fight Crime: Invest in Kids, 2003; Lev-Wiesel, Nuttman-Shwartz, & Sternberg, 2006). New Zealand produces higher statistics, although from a small sample of 25, with emotional abuse claiming the highest percentage at 70% for catty gossip,

telling tales, or being 'narked' on by children (Maxwell & Carroll-Lind, 1997). This was experienced equally between boys and girls. Forty nine percent had been punched, hit, kicked, or beaten by children, and 40% were asked unwanted questions of a sexual nature.

Additionally, witnessing violence or abuse was high in this New Zealand sample. Sixty four percent of children reported watching other children being threatened, frightened or called names by other children, 62% witnessed children being ganged up on or left out, 53% watched one-sided physical abuse, while 51% had witnessed a physical fight (a punch) by children (Maxwell & Carroll-Lind, 1997).

The impact of bullying is often minimised (Maxwell & Carroll-Lind, 1997). Whilst single minor episodes might have minimum lasting effects, frequent and severe bullying can have long-lasting consequences. Sourander, Helstela, Helenius, and Piha (2000) found that victimization and bullying often persist and are associated with severe behavioural and emotional problems. O'Moore and Kirkham (2001) found a strong correlation between bullying and self-esteem. Children commonly rated physical and emotional abuse as being one of the worst things that had ever happened to them (Maxwell & Carroll-Lind, 1997). The outcome or 'hurt' was more often than not described as emotional and was reported as long-lasting. Maxwell and Carroll-Lind (1997) inform that most adults will recall personal bullying for the duration of their lives.

Bullying and Depression

Both bullies and victims can endure ongoing psychological issues. Regarding the bully, research has produced conflicting results. Many researchers are of the opinion that bullies have average to high self-esteem (e.g. Gervay, 2007; Olweus, 1993), whilst others report low self-concept and depressive symptoms in those who bully (e.g. Dopheide, 2006; Karstadt & Woods, 1999). Juvonen, Graham, and Schuster (2003) acknowledge that whilst they consider most bullies to be psychologically strong, the 'bully-victim' (named the anxious bully by Lawson, 1994) is the most troubled displaying signs of low self-esteem, anxiety and

depression. It is thought that 12.5% of bullies suffer depression (Kumpulainen, Rasanen, & Puura, 2001). The majority of bullies are thought to come from troubled family backgrounds, with parents commonly being hostile, indifferent, and rejecting towards their children (Olweus, 1994).

Conversely, victims of bullying are thought to come from overprotective families who recognise anxiety and insecurity in their child and therefore wish to shield him or her from harm (Smokowski & Kopasz, 2005). There is no doubt that short and long-term effects of victimization include low self-esteem, anxiety, and depression which can continue into adulthood (Bond, Carlin, Thomas, Rubin, & Patton, 2001; Fekkes, Pijpers, Fredriks, Vogels, & Verloove-Vanhorick, 2006; Gervay, 2007; Fight Crime: Invest in Kids, 2003; Smokowski & Kopasz, 2005). Not only does victimization cause conditions such as depression, depressive symptoms in a child can increase the risk of them becoming victims (Fekkes et al., 2006).

Furthermore, Rigby (2001) found that the level of social support was a significant factor. An adolescent who suffered frequent bullying and had little or no social support had an increased chance of developing a mental illness.

Additional to depression, or perhaps as a consequence, bullied children are more likely to contemplate or attempt self-harm or suicide compared to non-bullied children (Coggan, Bennett, Hooper, & Dickinson, 2003; Maxwell & Carroll-Lind, 1997; Rigby, 2001; Schuster, 2001). Maxwell and Carroll-Lind (1997) cite newspaper articles from the Dominion (22/10/97) outlining the serious nature and consequences of bullying. Bullying was identified as a factor in a youth suicide, as the contributor to serious injuries in a child who attempted to break up a fight, and as the driving force behind a youth murder. In a study of Finnish adolescents between the ages of 14 and 16, Kaltiala-Heino, Rimpela, Rantanen, and Rimpela (2000) concluded that both victims of bullying, the bully-victim and the bullies themselves were at increased risk of depression, self harm and suicide.

Furthermore, those who witness bullying can suffer long-term consequences. Shellard (2002) reports that bystanders witnessing bullying are at

increased risk of suffering a variety of psychological symptoms including depression and anxiety.

Loss

Losses, in particular bereavement which is recognised as the most stressful and personally traumatic event that can occur throughout one's life cycle (McHorney & Mor, 1988), tend to affect individuals differently at different ages. Childhood and adolescent bereavement often has emotional consequences such as anxiety and depression (Christ, Siegel, & Christ, 2002; Dowdney, 2000). However, the issues may vary according to the age of the child. Jellinek, Bostic, and Schlozman (2007), regarding survivors of student suicide, report typical responses throughout the levels of schooling. Elementary students are inclined to focus on the impact on their immediate lives, while middle grades focus more on how they could or should have prevented the death, and high school students tend to recognise and focus on the finality of the death. Consequently, each level benefits from different types of support. Following parental death, in a sample of 13-18 year-olds, Harris (1991) reported that, beyond the expected initial intense responses, symptoms relating to stress were most salient and enduring. A higher sustained level of distress was reported as compared to the distress experienced by adult children at the death of a parent. Agid et al. (1999) found that early parental loss through permanent separation or death renders individuals vulnerable to adult psychiatric illnesses. This is not a new finding.

Loss and Depression

In 1963, Beck, Sethi, and Tuthill assessed depression scores of 297 both in- and out-patients. Twenty seven percent of 100 patients with high and 12% of 100 with low depression scores had lost a parent before age 16. In the more depressed group, parental loss before the age of four was noticeably higher. In a study including 1,483 depressed and 1,059 non-depressed psychiatric patients, more depressed patients had lost their fathers before the age of 15 than non-depressed patients (Hill & Price, 1967). Female patients had the most marked difference,

particularly when the loss occurred between ages 10-14. The two groups showed no difference with regard to maternal bereavement. Parker and Manicavasagar (1986) studied the relationship between maternal bereavement and adult depression in 79 women who lost their mothers by death in childhood. Sudden death of the mother, the child being older, perceived lack of family support in the early stages, a longer delay in the introduction of a stepmother, and the perception that any replacement mother figure is inadequate were all associated with adult depression.

Beyond bereavement there are many other types of losses experienced throughout life, for example, loss of employment, loss of a home, loss of a lifestyle on retirement, and loss of a loved one through separation or divorce. Yet the only type of loss acknowledged in diagnostic manuals such as the Diagnostic and Statistical Manual of Mental Disorders-IV-TR (DSM-IV-TR) (American Psychiatric Association (APA), 2000) for depression is bereavement (Kotz, 2007). The DSM-IV-TR allows a period of two months for mourning after which time, if depressive symptoms persist, the diagnosis becomes major depressive disorder. Yet mourning can last for much longer than two months (Kotz, 2007). Bonanno (2004) maintains that normal grieving symptoms for 35 to 65% of bereaved people tend to resolve themselves without treatment between two and four months. Complicated grief can take a lot longer (Viedermann, 1995). Approximately 15 to 35% of depressed individuals will recover within one to two years (Bonanno, 2004). A further 10 to 15% are purported to suffer persistent grief and subsequent depression perpetuating in chronic dysfunction long term (Bonanno, Moskowitz, Papa, & Folkman, 2005). Many bereavement programmes for families extend to one year. However, it is being recognised that for many this period of time is not enough (Ng, 2005). In fact, Reid and Dixon (2000) found higher levels of depressive symptoms and grief in those who had experienced loss of a loved one within the last five years compared to those who had not experienced such a loss. Furthermore, should there not be a mourning period for other losses as well? Should these other losses be treated as major depression which is the current conclusion by most doctors (Kotz, 2007)? Or should they be

treated as part of a grieving process for which specific guidance is required in order for the sufferer to move on in life in a healthy manner? In a review of studies published by Wakefield and First (2007, cited in Kotz, 2007), they revealed that almost 25% of people fitting the description of clinical depression were in fact experiencing normal signs of sadness. When these normal signs of sadness are diagnosed as clinical depression and antidepressants are the result, healthy grieving may be inhibited and the grieving process prolonged (Kotz, 2007).

Injury and Illness

There is less documented research available on the long-term effects into adulthood of childhood illness or injury. Short-term effects documented in hospital records suggest that the developmental level of the child and the acuteness of the illness appear to influence the type of response by the child to the event (Broad & Wheeler, 2006). Rennick, Johnston, Dougherty, Platt, and Ritchie (2002) found that a younger child with more serious illness or invasive procedures was more likely to develop adverse affects and PTSD. However Scragg, Jones, and Fauvel (2001) found that, although being younger and having a longer stay in an intensive care unit were predictive of higher rates of PTSD, they did not increase the chances of developing anxiety or depressive disorders. In another study, being younger predicted higher levels of anxiety while being female predicted higher levels of both anxiety and depression (Rattray, Johnston, & Wildsmith, 2005). They found that the severity of illness had no bearing on the psychological outcome with the exception of the length of time in hospital.

Summary

Trauma was first associated with psychopathology over 100 years ago. It is the result of an individual's adaptation to horrific life events and experiences. Some individuals are more resilient than others to the effects of trauma. Traumatic events include but are not limited to family violence (including emotional and

physical abuse, and neglect), bullying, loss, and injury and illness. Childhood trauma is a risk factor for depression.

Childhood abuse has negative consequences including increased aggression, the development of an association between love and pain, anxiety, depression, and problems associated with poor attachment. Abuse in childhood has been purported to deform a child's personality. Poor regulation of affect and major depression are associated with childhood abuse.

Sexual abuse has long-lasting emotional and behavioural difficulties. However, emotional abuse has a higher association with depression and anxiety compared to sexual and physical abuse. One-off abuse can be as damaging as continuous abuse, and witnessing abuse is also associated with anxiety and depression.

Bullying is a form of aggression aimed at a weaker victim. Four categories of bullying have been identified: physical; verbal; relational; and reactive, all having psychological consequences. It is widespread in schools, with statistics in New Zealand high compared to other countries, ensuring that witnessing bullying behaviour is problematic in New Zealand schools. Witnessing bullying behaviour also results in long-term detrimental consequences. Children consider being bullied worse than drugs and alcohol, pressure to have sex, AIDS, and racism.

The impact of bullying is often minimized. However, long-lasting behavioural and emotional problems are common consequences for both the bully and the victim. Regarding the bully, research is inconclusive with some finding bullies to have high self-esteem and some low self-esteem. It is thought that 12.5% of bullies suffer depression. Most come from troubled backgrounds with parents who are often hostile, indifferent, and rejecting.

Conversely, victims of bullies are thought to come from overprotective families, have low self-esteem, anxiety, and depression. Children who have been bullied are more likely to contemplate or attempt self-harm or suicide compared to children who have not been bullied. Social support was identified as a significant protective factor.

Loss is commonly thought of as the death of a loved one. Bereavement has been found to affect individuals differently depending on the age it was experienced. Consequences are commonly anxiety and depression, with depression being the common consequence when a parent is lost at an early age. The required levels of support vary depending on the age and development of the child.

Beyond bereavement, common losses include the loss of employment, loss of home, loss of a lifestyle due to retirement, and the loss of a loved one through separation or divorce. However, the DSM-IV-TR for depression only allows for bereavement with a mourning period of two months which is considered too short by many researchers. Two years is a more common accepted timeline. Furthermore, a review of studies revealed that 25% of clinically depressed individuals were in fact showing normal signs of sadness for which antidepressants might have inhibited natural grieving processes.

Documented long-term effects of childhood injury and illnesses are sparse. Short-term records show that the developmental stage of the child and acuteness of the illness appears to have the greatest effect on the consequences. The length of time spent in hospital affected the severity of psychological problems. The most common consequences of childhood illnesses and injury are PTSD, anxiety and depression.

Chapter 7

Method

Chapter 7 discusses the rationale for using qualitative enquiry, offers a brief overview of the Dietary Intervention Study (DIS) to give a background to the recruitment of the participants for this study, and includes the method for the current study. Included is the rationale for using thematic analysis which incorporates discussion on the particular style of thematic analysis adopted.

Rationale

In choosing the methodology for this research, the primary consideration was how best to investigate the research topic; that is, exploring all possible factors from each participant's perspective relating to their reflections of the context and course of their depression. This included inquiring about their upbringing, significant life events, what they consider caused or contributed to their depressive state, and what has helped their recovery. Emphasis was on their experience as it is imperative to understand human experience in psychology. It was pertinent to investigate factors associated with recovery as the majority of the participants in the DIS reported reduced depressive symptoms over the course of that study.

This research aimed to describe identified themes within the context of the participants' unique life experiences and how these experiences might shape their behaviour. As such, it was based on an essentialist or realist theoretical framework, exploring participants' life experiences, the meanings they attach to these and the participants' reality. Thematic analysis is a widely used method for analysing qualitative data in various fields of research including psychology (Boyatzis, 1998; Braun & Clarke, 2006). It is a flexible methodology in that it is not linked to specific theories.

The current research was exploratory and was an attempt to construct a psychological understanding of the participants' depression and improvement in

depressive symptoms embedded in their actual lived experiences. For this reason an inductive (from the bottom up) approach was adopted which, according to Boyatzis (1998), is typically favoured by clinical psychologists. Using an inductive form of thematic analysis bears some resemblance to grounded theory in that the identified themes are strongly linked to the actual data (Braun & Clarke, 2006). For this reason, the themes identified may or may not relate specifically to the research topic, thus minimizing the risk of omitting data that might be relevant and even crucial to the investigation.

Furthermore, analysis was conducted at a semantic level. This level of analysis ensures that identified themes remain largely the perspective of the participants. However, discussion at this level involves deeper analysis and interpretation at which time the significance of the identified patterns are theorized and compared to previous literature.

Previous Study: The Dietary Intervention Study (DIS)

The aim of the DIS was to ascertain the effects of adding omega 3 fish oil, including both EPA and DHA, to existing therapy for a current major depressive episode (Silvers, Woolley, Hamilton, Watts, & Watson, 2005). The study was approved by the Massey University, the Manawatu-Whanganui, and the Wellington Human Ethics Committees, and was run conjointly with Massey University and the New Zealand Institute for Crop & Food Research. Recruitment for the DIS was from a community sample of adults between the ages of 18 and 65 years, through a Community Mental Health Service, general practices, and advertisements in free community papers in Wanganui, Palmerston North, Kapiti Coast, and Wellington. The majority of participants were respondents to the advertisements. A phone number was set up for prospective participants to gather personal details. From approximately 500 respondents 72 were eligible to take part in the study. All participants had a DSM-IV diagnosis of unipolar depression with current depressive symptoms. They were accepted into the trial if they had received a diagnosis for an anxiety disorder. However, any other psychological or psychiatric disorder was not included.

The DIS was a randomised double-blind placebo-controlled 12-week trial in which participants were split into two groups: an experimental group in which the participants were given fish oil containing n-3 fatty acids; and a control group in which participants received olive oil, an oil known not to increase n-3 fatty acid levels. Participants comprised 41 women and 31 men. A number of psychologically relevant tests were administered to assess levels of depression [Beck Depression Inventory-II (BDI-II) and the Hamilton Depression Inventory-Short Form (HDI-SF)], health beliefs (Health Beliefs Model (HBM), and perceived stress (Perceived Stress Scale-10 (PSS-10)], as well as the collection of relevant health and personal history [SF-36 and Personal History Questionnaire (PHQ)]. In addition, information was provided about diagnosis and treatment provided by the participants' nominated health professional (GP, psychiatrist or psychologist). During a three month period, or 12-week block, participants were required to complete the questionnaires beforehand as a baseline, during, and at completion, plus have blood tests every week to clinically assess biochemical effects of the supplement. Participants were made aware of, and asked to sign a declaration confirming that information gathered was for research purposes only and that no treatment of any kind would be provided by the Massey University Psychology Clinic (see Appendix A).

Results demonstrated that fish oil could not be singled out as improving mood when both groups showed significant improvement in depressive symptoms within the first two weeks of the study (Silvers et al., 2005). Furthermore, this improvement was maintained throughout the study. In addition, testing various covariates "age, reason for taking part in the research, initial hopefulness about the supplement, alcohol intake, level of physical activity and type of medication" (p. 214) showed no evidence that they were associated with the improvement of mood.

The DIS researchers arranged for one of them to interview consenting participants one year after the study was completed. It was explained to participants at the onset of the DIS that they would be contacted one year after the DIS ended for an in-depth interview of their experiences of depression.

Permission to record and transcribe the interviews was included in the original ethics approval. Participants from the DIS were contacted by letter, as arranged, for this final research phase (see Appendix B). Thirteen individuals volunteered. They comprised five women and eight men.

The Interviews

The 13 participants undertook semi-structured in-depth audio-recorded interviews, each ranging in length from 45 to 90 minutes. The interviews were conducted by one of the researchers involved in the original research, not the present researcher. Questions were structured based on findings and questions raised during the original study (Appendix C). They included information from topics entered into clinical journals and informal conversations and reflections between the researchers involved in the DIS and the participants. Enquiry encompassed familial relationships, perceptions of the causes of their depression, earliest recollections, trauma, changes made since completion of the original study, advice participants would give to friends with depression, and what aspects of the original study the participants found helpful or not helpful. See Appendix C for the interview guideline. The interviews were transcribed and set aside for future analysis.

Personal History Questionnaire – Final Phase (PHQ-F)

The PHQ-F was developed specifically for this study based on a previously adapted version (the PHQ) used for Hamilton's (2003) compliance study. Hamilton's (2003) version was adapted from a longer questionnaire developed by the Massey University Psychology Clinic which is used to obtain demographic and mental health information from new clients. The qualitative questions from the PHQ-F used in this study included questions more specific to life experiences, as well as sequential life history memories beginning with the earliest memory. See Appendix D to view the questions used in the current study.

Reflecting on the Research Study

Reflecting on the Research Study was a one-page form on which participants were asked to mark or rate what aspects of the Dietary Intervention Study were most helpful for them. They included taking the supplement, the opportunity to tell their stories, the support of the researcher over 12 weeks, knowing that they might be able to help others, being part of a research programme, and the extent to which being in the DIS was helpful to them (see Appendix E).

The Present Study

The interview data for the 13 volunteers were made available to the present researcher for her to undertake an in-depth exploration of the interviewees' experiences of life context and depression before, during and after completion of the DIS, making use of their increased level of awareness at this point in their lives.

Participants

The thirteen participants for the present study were made up of eight males and five females as shown in Table 1. Also shown is the age range to which each participant belonged. All of the participants described themselves as New Zealand Pakeha/European except for participant number 1, *male* who identified as 'other'.

Time 2 indicates how much depression bothered the participant at the time of this study, as asked in the PHQ-F. The same question was asked in the original PHQ at the beginning of the DIS which is reflected in Time 1. As can be seen from Table 1, eight of the participants reported reductions in how much depression bothered them from time 1 to time 2.

Table 1. Overview of gender, age ranges, and how much depression bothered the participants at Time 1 and Time 2

ID	Male	Female	18-25	26-35	36-45	46-55	56-65	Time 1	Time 2
1	x				x			8	7
6	x				x			5	3
11	x						x	9	3
12	x					x		8	8
18	x		x					7	3
21	x		x					5	4
24	x					x		5	2
33	x				x			7	8
56		x			x			5	6
66		x	x					5	6
67		x			x			8	3
69		x		x				3	3
82		x			x			4	1

Analytic Procedure

Considering the number of studies that have adopted a thematic analytical approach, and the number of years thematic analysis has been in use, there is little documented on an actual procedure. The present researcher made use of the six phases of thematic analysis as described by Braun and Clarke (2006). Additionally, Boyatzis' (1998) descriptions of particular aspects of the phases relating to the specific style of analysis adopted in this research were drawn on to aid analysis.

The first phase of analysis was to become familiar with the data. This involved reading and rereading the transcripts, PHQ-Fs, and Reflecting on the Research Study, making notes of initial ideas on the transcripts and forms.

Phase two involved generating initial codes across the entire data set, and collating data relevant to each code. The first step of this phase was to number each paragraph spoken by the participant within each transcript. Working through the transcripts and forms one at a time, codes were identified and labelled in separate word documents for each participant. Codes were listed in alphabetical order with the relevant section of transcript under each code labelled with the paragraph and page number. This enabled quick reference to the full text when required.

Once all transcripts and forms were coded in this manner, in a separate word document, a full list of codes was collated with each participant's identification number beside it. For example: guilt - DI001, DI021, DI056. When different code names had been used for different participants but essentially had the same meaning the codes were joined with a single name. Many extracts attracted more than one code allowing them to appear in more than one potential theme. This is acceptable and expected according to Braun and Clarke (2006).

The third phase involved searching for themes. To begin this phase, codes were grouped into similar topic areas or potential themes, by opening another word document called 'potential themes'. Each group was given a temporary title with the codes and extracts collated into each group. All codes were looked at individually and placed under one or more potential themes, or in a miscellaneous 'theme' for codes which did not fit well elsewhere at this stage. The initial thematic map was a word document of a potential title of each identified theme with a list of possible sub-themes under each one.

Reviewing these themes made up the fourth phase of analysis. This was a difficult phase as it involved reviewing the identified potential themes at the coded level of data extracts, as well as reviewing the validity of each theme in relation to the entire data set. It was a time consuming process with the initial thematic map being manipulated and refined until the final thematic map of the analysis was generated.

The fifth phase of analysis involved continued defining and naming the themes, and refining the specifics of each theme. Sub-themes within themes were

identified to enable more structured detail of each theme. It was this stage of analysis which determined which order the themes would be reported.

The final phase of analysis included reporting each finding with examples of data extracts which best demonstrated the theme. This was done in a narrative fashion to capture the essence of depression and associated factors in direct relation to the perspectives of the participants. Additionally, analysis included discussion relating to previous literature which helped emphasise the themes and highlight areas which require further research.

Reflexivity

To avoid qualitative research being labelled as untrustworthy or biased, it is important as a researcher to be reflexive and constantly evaluate one's self-awareness and involvement in the topic and data. Reflexivity has been defined as "thoughtful, conscious self-awareness" (Finlay, 2002, p. 532). As the researcher of this current study I have constantly been aware of how my life experience may impact on analysis of the interviews. I have experienced many of the life stressors that the participants have experienced such as divorce, subsequently bringing up three children on my own as well as the loss of my father while writing my Honours dissertation. However, I have never been diagnosed with clinical depression. The interpretation of the interviews, therefore, comes from someone who empathised with the participants but had not experienced depression as they had.

Seven years of psychology training plus my familiarity with past studies surrounding the research topic also impact on my analysis. Braun and Clarke (2006) note that "researchers cannot free themselves of their theoretical and epistemological commitments, and data are not coded in an epistemological vacuum" (p. 84). However, this should by no means render this research meaningless or irrelevant. Rather, it acknowledges the impossibility of being totally without perspective or objectiveness, and "it should be seen as part of a process of making research more accountable, more transparent and easier to evaluate" (Coyle, 2000, p. 265). Indeed, my psychology training, knowledge, and

experience in the field can thus be viewed as a strength which I bring to the analysis.

Chapter 8

Results

Identified themes are inclusive of results from analysis of the interviews, qualitative data collected from the PHQ-Fs and the form 'Reflecting on the Research Study'.

After reading and rereading all texts a number of times searching for patterns, four main themes were identified: *Stress and Anxiety - Causes and Consequences*, *Negative Attachment Styles*, *Maintaining/Unhelpful Factors*, and *Positive Perceptions and Assessments*. Each theme has sub-themes in order to help give structure to the main theme and to demonstrate the levels and depth of findings within each theme as suggested by Braun and Clarke (2006). The themes are outlined and discussed in this and the following three chapters.

Stress and Anxiety - Causes and Consequences

The predominant theme identified was that of stress. In addition to this theme, it was noted in the themes *Negative Attachment Styles* and *Maintaining/Unhelpful Factors*, where it was evidenced in the coping styles employed by the participants.

All 13 participants reported indications of stress, anxiety or both. For the majority the stress began early in life and compounded over the years. Indicators were many and varied and included externalizing symptoms such as anger and volatility, and internalizing symptoms such as withdrawal and holding resentment. To help organise findings, the theme has been reported within four sub-themes which were identified as most common across participants: *Stress as the Core and Trigger of Depression*; *Loss and Adjustment as Common Stressors*; *Stress at School including Bullying*; and *Anxiety*.

Stress as the Core and Trigger of Depression

Half of the participants attributed stress to be at the core of their depression. Much research has reported stress and depression as being correlated (e.g. Brown & Harris, 1989; Hammen, 2005; Pizzagalli et al., 2007), not inferring that one causes the other. This research suggests that, from the depressed individual's perspective, stress causes depression or induces depressive symptoms. Other research supports this finding (e.g. Lloyd, 1980; Kendler et al., 1999).

Unidentified Stress

Most studies regarding the relationship between stress and depression focus on specific stressful life events (Cohen et al., 2007). While many of the participants in this study indicated that specific stressful life events caused their depression, some of them could not identify a specific stressor.

INT: *Have you noticed any other factors that trigger depression for you?*

Stress. (66, female)

I just put it down to being so stressed out, not coping. Yeah. It's many factors but putting your finger on it, I don't know. (12, male)

This finding emulates Hammen's (2005) and Mazure's (1998) studies which found that increased stress induced the onset of depression. Matthieu and Ivanoff (2006) described the consequences of the strain of constantly responding to stressful situations over time as detrimental.

Furthermore, coping, or not coping is implicated as problematic, seen particularly in the second participant (12, male). As discussed in the literature review, how an individual copes with a stressor or stressors is likely to determine the severity of psychological distress. For this reason, it is imperative as part of a clinical assessment to determine the coping strategies employed by the presenting individual (Matthieu & Ivanoff, 2006).

Relationships

The following participants identified stress from problematic relationships to be the core of their depression. For two of them the breakup of their marriage was identified as being their first bad attack of depression.

...three months after I had this breakdown, I met this girl and that was enough. That did too much. I had my breakdown in '89 and I met her in 1990 and those two years were just sheer murder. (6, male)

INT: *So am I hearing that for you, your current issues of depression are very much tied up with the state of your marriage and relationships?*

Yeah, they are, yeah. (69, female)

That [marriage break-up] was when I probably had my first real bad bout of depression. (56, female)

Previous studies also found stress to be related to problematic relationships (Fu & Parahoo, 2009; Granek, 2006; Lackey, 2008; and Lawrence et al., 2006). Unlike Fu and Parahoo's (2009) Taiwanese participants whose depression was rooted in unhappy marital relationships due to cultural expectations, participants in this study were more inclined to have divorced from an unhappy marriage. Participants from both studies shared the same consequences which were feelings of isolation and loneliness. Highlighted is the need to consider culture within individual experiences when assessing and treating depression which concurs with Lawrence et al.'s, (2006) findings that actions and meanings vary across cultures.

A previous Canadian study examined the relationship between marital disruption and major depression and found it to be bidirectional (Bulloch, Williams, Lavorato, & Patten, 2009). Having major depression increased the risk of marital disruption. As well, those with marital disruption and divorce were at a greater risk of developing major depression. Clinically, their findings indicate that there is an association between depression and marital status, and that clinicians

need to clarify that relationship when treating individuals with depression. Participant 6 (male), quoted above was likely to have been in a depressed state when he entered his next relationship which would impact on the success of that relationship. On the other hand, participant 56's (female) perception was that her depression was the result of her dissolved marriage. Participant 69 (female) was aware that her depression was related to her problematic relationship. It might be helpful in such situations to actively manage marital and relationship problems which could subsequently decrease depressive symptoms.

Trauma

Eleven of the 13 participants had perceived one or more life experiences to be traumatic. The majority of those experiences occurred in their earlier years. Some participants acknowledged the significance of these events with regard to their depression.

Previous studies confirm that early trauma and negative life events can lead to depression (Dopheide, 2006; Feely, Sines, & Long, 2007). Feely et al. (2007), in their grounded theory research, found that participants felt that early negative life experiences influenced their current sense of self-worth.

Seven of the participants had described earliest traumatic recollections, five of which were discussed in depth in the interviews and two that were listed as their earliest memory in the PHQ-F, with the researcher judging them as probably traumatic events as the memory was fixed. These included getting sand in her eye at kindergarten aged four (66, female) and a neighbour falling out of a tree age five and breaking her arm. The participant was taking her home but abandoned her half way (56, female).

Two participants' earliest memories related to childhood illnesses which were traumatic experiences for both of them.

There were some issues that I was addressing that had to do with an episode in hospital when I was four. It's really complex.

INT: *Tell me about going to hospital when you were four.*

Um, I had a kidney infection and I had some things done to me that nobody explained what was going on and um, and I guess, being kidney, being, you know, certain areas that they deal with that I was uncomfortable with and it manifested its way into some sort of almost form of feeling like I was abused even though it wasn't but it was kind of how my brain made it feel like and that would have to do with, partly to do with my relationship with my Dad because it was male doctors doing things to me. (69, female)

The biggest part of it for me was a really strong feeling of betrayal because nobody told me what they were doing and someone was doing stuff behind me. "There will be a wee prick now" and then I couldn't feel anything of course and they did the lumbar puncture and so on and meanwhile there was a nurse on my other side just chatting away, really nice, really friendly. Sort of like these were my friends kind of and then I was taken back to the ward and sometime later I don't know whether I was scratching but I suddenly discovered I had this big crusty, I guess the fluid must have come out, crusty sort of stuff and one area of it was a huge, great big thing and I suddenly realised that these people who had been really nice and friendly to me had actually been, they had cut me or something. (33, male)

The above participants both felt a sense of abuse and/or betrayal during or after their hospital procedure. Participant 69 (female) attributed the effects to have had an impact on her relationship with her father because it was male doctors performing her operation. For participant 33 (male), the strong feelings of betrayal felt during his operation, although not specified by him, could well have shaped his future trust in others.

Documented evidence of long-term effects of injury and illness in childhood is sparse. Adverse effects most often acknowledged from short-term studies are PTSD (Rennick et al., 2002; Scragg et al., 2001), or anxiety (Rattray et al., 2005). Scragg et al. (2001) and Rattray et al. (2005) found that the length of time spent in hospital was more predictive of a negative psychological outcome than the

severity of the illness. Neither of the above participants discussed the length of their hospital stay. Both were young and being younger predicted higher levels of anxiety while being female predicted both anxiety and depression according to Rattray et al. (2005). Scragg et al. (2001) found no such connection to anxiety or depression.

Participant 33 (male) had a second earliest recollection which was also traumatic, likely compounding and increasing negative psychological distress.

*That was all sort of tied up with that sort of general sadness that seemed to come out of the viral meningitis and somewhere around that time I remember getting really slaughtered by mosquitoes, all over my head, all over my face and they all swelled up and I kind of went feverish. In those days Mum and Dad were taking us along to Sunday school, just so that we could, you know, experience it and make our own decision so I was sort of aware of God and everything I suppose. All kids are anyway [?] Sunday school. I remember really clearly, remember thinking to myself what did God make mosquitoes for? I couldn't see why, you know, a good and just God whatever, would make something that was making me feel so miserable which was just, yeah, entirely self centred, an eight year old thought or whatever. But my next thought was, why did he make me and I couldn't see any reason why I had any more right or anything or purpose than the mosquito and that could have been like sort of seeing looking at it semi objectively as I can, that actually could have been the great realisation seeing where, how things fit together and, you know, that mosquito had as much right to be around as I do. [?] I took it as a like, I guess, [?] crisis sort of thing and that's been with me ever since I guess. I don't think that's unusual but it's just those two, the viral meningitis and somebody being able to come up with a [?] good reason why I was alive but they are the two things that I feel like formed my certain perceptions about how the world is.
(33, male)*

Participant 33 specified more clearly here how his experience with viral meningitis and then being slaughtered by mosquitoes shaped his experience of the world. He described an analysis which guided and shaped his perception about the purpose of being alive as well as his perception of how the world is. This appeared to be quite traumatic for him as he described the events as a “crisis sort of thing” that had remained with him.

One illness in childhood is known to cause psychological distress in some children. Therefore, it could be expected that two illnesses in a relatively short time span will likely compound distress. Kaufman and Kaufman (2005) discussed the effects of compounding distress with regard to bereavement in childhood. They found that how a child processed the first loss had some bearing on how subsequent losses were managed. Additionally, the level and type of support offered during multiple bereavements in childhood affected a child’s ability to cope. Each participant’s perceived level and type of support received is unclear. It is possible that the level of discussion with the child regarding the illness was minimal, allowing the child to create their own, perhaps unhelpful explanations. Further research in the area of childhood illness is required. In particular, two areas are highlighted from my research. The long-term psychological effects, as well as the level of disclosure of information regarding the illness and procedures required which would be most beneficial for the child to process the experience and emerge from it psychologically unharmed.

The above participant was not the only one to experience more than one traumatic incident. For example:

Um, one day at primary I think I was like, standard 2, the guy would have been about standard 4, back in '86. They were having a fight and some guy had a small pocket knife. The blade was only yay long. Instead of getting who he wanted I ended up being in the way and so it was me. (21, male)

INT: *You had a couple of fairly major traumas happen when you were younger. You had a friend who was killed. How did that affect you?*

Um, quite bad. I can still remember just about everything that happened that afternoon. It would have been ten years ago last week. (21, male)

'96 – What happened there? It's a good question. I can't actually remember. Ah, yeah, I can actually. I had a bit of an incident in the square. Yeah, I remember that night. Yeah, I do now. Um, I had been training with St John at the time and got a call out to a crash, just outside the plaza on Church Street and the guys ended up getting another call out. I wasn't needed so I says well, I may as well walk home from here. It's about ten minutes away and next thing there's about half a dozen Maori or Islanders and they had a baseball bat and [?] head to toe. (21, male)

When he was giving Mum a hiding I would be sitting in my bedroom, crying. (12, male)

It's about round about the age of ten I was sexually abused and I'm going to go for counselling but... (12, male)

Although not made explicit by these participants, it would be expected that ongoing traumatic incidents would help shape their view of themselves and the world as with participants 69 (female) and 33 (male), affecting how they interact with people within their world. Each subsequent trauma would compound distress and, again the type and level of support would have a bearing on how the participants coped with each successive trauma. Dennis et al. (2009) reported similar findings in that 79% of their participants with major depressive disorder had reported multiple traumas compared to 46% in the control group.

A further two participants, whilst not their earliest memories, experienced trauma at a young age.

INT: *You said earlier and in your personal history questionnaire that it was quite traumatic for you when your sister came along. Can you tell me a little bit about that?*

I don't remember really why it was traumatic. I guess it was traumatic because suddenly I was second class citizen. I never thought of myself as being like that but it must have been traumatic for me to want to push her in the fire. (11, male)

I was scared when she was in intensive care one time. She told me she didn't want to see me. I was about eight and I didn't understand. I didn't know why Mum didn't want to see me. I thought I must have done something wrong but I didn't. It was just Mum didn't want us to see her like that but, yeah, it was awful. (66, female)

For two male participants the trauma did not stop at a younger age. Listed in their PHQ-F for memories in the 31-35 age brackets, (6, male) and (11, male) became fathers which they described as a traumatic experience.

It is clear that many of the participants experienced trauma at a young age. It is not clear whether the trauma itself was directly related to their depression as an adult. However, for some they attributed their trauma to how they viewed themselves, their relationships, and the world they lived in. Evident from some of the above participants was that their distress was related to the level of understanding of the situation. Quotes such as “nobody explained what was going on” (69, female), “strong feeling of betrayal” (33, male), “I didn't know why mum didn't want to see me. I thought I must have done something wrong...” (66, female) indicate that the type of support offered at the time lacked adequate explanations. When detail was left out their brain filled in the gaps with their own level of understanding (“kind of how my brain made it feel like” (69, female)). It would seem that various types of trauma elicit similar results as childhood bereavement discussed by Kaufman and Kaufman (2005).

Loss and Adjustment as Common Stressors

A loss is most often a traumatic event. It is discussed under its own sub-heading as losses were varied and prevalent throughout the interviews. Losses ranged from death, loss of relationships such as the marriage break-ups discussed in *relationships*, parental divorce, loss of a familiar environment and support networks as a result of moving, to loss of employment, and many suffered multiple losses.

All 13 participants had suffered some form of loss. Many of these losses were statements in the PHQ-F with no further comments regarding how, if at all the loss related to their depression. For example, one participant stated in his PHQ-F that he lost a baby which could be assumed would be traumatic. However, he did not mention this loss in his interview. Another male participant's first depression was in recent years. He was unable to identify specific causes but had suffered multiple losses over the years including the recent loss of his successful business due to ill health. These distinctions of the participant's perspective regarding the effect of loss on their depression will be made in the following interpretation where pertinent.

Death

Nearly all of the participants had experienced the loss of a loved one. One or both parents were the most common loss with the loss of a baby, child, or miscarriage next. Other losses of loved ones included in-laws, grand and great grand parents, a cousin to suicide and a friend in an accident. Some of these deaths were listed in the PHQ-F with no discussion on their effect. Some spoke of the deaths in their interview, often by way of stating a fact. Others acknowledged the stress felt whether they described it as being directly related to the death or stress manifested in other areas of their life. The following participant acknowledged that his loss had a lasting effect.

INT: *You had a couple of fairly major traumas happen when you were younger.*

You had a friend who was killed. How did that affect you?

Um, quite bad. I can still remember just about everything that happened that afternoon. It would have been ten years ago last week...Pretty messed up. I ended up being driven home by Granddad and the cop that responded to the crash turned up a couple of hours later and we talked from the beginning to the end and he got my first statement there and then. I didn't sleep for God knows how many days, let alone eat...

INT: *So why do you think at this time it would be valuable to go and see a counsellor?*

Don't know. No. Probably like it was ten years since [friend] died, [friend] was killed last week. Nearly saw one of my friends done on Sunday morning.

INT: *Okay. So it's been on your mind a wee bit, those kinds of things?*

Yeah. (21, male)

Although early research found no connection between death in childhood and adult psychiatric illness (Tennant, Smith & Bebbington, 1981), more recent research has found that childhood bereavement often results in depression and anxiety (Christ et al., 2002; Dowdney, 2000; Jellinek et al., 2007; Kaufman & Kaufman, 2005). How a child copes with it depends on the age of the child (Jellinek et al., 2007), as well as the level of support received throughout (Kaufman & Kaufman, 2005).

Furthermore, Kaufman and Kaufman (2005) note that the level and type of support offered during multiple bereavements in childhood affect a child's ability to cope. The following participant described problems adjusting to Intermediate School when, in the same year he lost two grandparents who were both living with him.

Oh, just different people there [Intermediate School], a new environment and at the same stage, when my Granddad and Great Granddad died and they're living at home with us. I don't know what it was. It was just

something different about intermediate and even though I enjoyed it and I made heaps of new friends, it still had a big effect on me. (18, male)

His reference to the deaths was brief with little understanding of the effect it might have had on him. From the researchers perspective, it could be expected that each death impacted on the next, compounding the grieving process. This would likely interfere with how he felt about school at that time. Again, the level of support he received at the time would likely have impacted on his ability to cope.

Multiple Losses

Similar results could be expected for participants who suffered multiple losses, including but not restricted to death, in quick succession. The following participant recognised the effect multiple losses had on her.

That was definitely in adult life and it was after I had left my husband. A combination of things going on, left my husband, felt very much alone. I had lost a baby, yeah so there was whew! (82, female)

Similarly, it would be expected that participants who experienced multiple losses occurring over a longer period of time could affect their ability to cope with each successive loss. The following participant is an example of one who suffered multiple losses over time showing the cumulative impact of stress.

I sort of I feel like I've missed out all the way along because when we were at home those memories have sort of been shut off and shut down completely... because they've got more memories and a closer bonding...[other siblings] (56, female)

...having to be with a group that were a year younger than me so once again, I had lost those friends, few friends that I had sort of gone up through college with...(56, female)

... I think about the same time [as second marriage broke up] I lost my own, my own natural mother died...I didn't have a very close relationship with her but it was just the fact that part of your own family you had lost...(56, female)

...custody issues...he wanted joint custody and me feeling that he wasn't the ideal parent... the oldest one [child] at about the age of nine, went to live with his father for a period of two years... I would only see my older son in the weekends...but the older one would be a stranger and losing a lot of his life. Even though he came back to me again from about the time that he was sixteen, it was still difficult to build a close relationship and there was a lot of experiences that he had living with his father...(56, female)

The above participant lost her biological mother at a young age. When her father remarried all physical memories of her biological mother were removed, and contact with older siblings who had left home was forbidden. This restricted her ability to explore understanding and meanings of life from family history and siblings which Bowen (1976, as cited in Gladding, 2011) found imperative to healthy development. Support was limited affecting her ability to cope.

Support

For many, their support system which appeared to be a key to successful coping was included as a loss.

Several of the participants felt the loss or lack of support and discussed it in terms of it contributing to their stress and/or depression. The following selected examples demonstrate that support extends beyond family and extended family.

For some participants, the sense of lack of support continued into adulthood with other relationships.

...and I lost family support because they [brothers & sisters] would come to see the parents but they would only be allowed to stay with my parents, they wouldn't be allowed to come out and see me... Nobody would stand up to my stepmother. We were told not to go and see my sisters in [city]. We weren't supposed to stay with them. (56, female)

I don't think they knew how to handle it really. My mother wanted people to leave me alone but that was, in some ways, the last thing I really needed at that stage. My father tried to have sympathy for me but he's not a sympathetic person. I don't really truly think they understood because in their life, things like that don't happen to their family. (6, male)

I think, like my in-laws totally don't cope with it. I mean, I won't even talk to them about it now. The first time I tried to, my father-in-law who's a doctor, made some comment to [husband] like oh, she should just get over it. I thought 'okay'! You try getting over it. Yeah, and I had a college lecturer who at one stage said if you walk around looking up, he was my counsellor, if you walk around looking up all the time then you won't get depressed. This was doing a communication course and we were allowed to do feedback every night so I wrote on it that "I don't like your attitude toward mental illness" because I didn't think that was, he was very good about it at all for anybody. (66, female)

As already discussed, the level and type of support received throughout various life stressors likely affects an individual's psychological outcome. Good social support was found to be associated with lower prevalence rates of depression in a study of older individuals in Quebec (Mechakra-Tahiri, Zunzunegui, Preville, & Dube, 2009).

Change/Adjustment

Sometimes as difficult as loss and often intertwined with a sense of loss is a period of change and adjustment. Over half of the participants discussed having to make changes or adjust to new situations, for example:

INT: *Right. Let me just sort of clarify. You married reasonably young, you were twenty-one and you've had two children in your early twenties?*

Yeah. Married at twenty-one, [daughter] at twenty-two and [?] at twenty-three.

INT: *Right, quite a life change?*

Umm and just before that I was diagnosed with Celiac disease just before I got married too, so I had an enormous amount of change in my early twenties. (69, female)

...and I think it was the change; it was such a complete change from being brought up in a more relaxed environment with brothers and sisters looking out for you to complete control. (56, female)

The majority of the participants attributed the change to an increase of some form of stress in their lives. Participant 56 (female) was able to recognise how the change from her previously relaxed environment to an environment of complete control had an affect on her.

Relocating

All of the participants had moved, most more than once. Five of the participants had moved between the ages of one and five and one participant moved every decade from the age bracket 21 to 25. Whilst some of the participants had only made note of having moved in their PHQ-F with no information on what effect it had, some found the stress of moving resulted in feelings of isolation and loneliness which they believed triggered their depressive episode, for example:

Yeah. The first six months was awful [being away from family]. I missed them so much I would ring them up. I was lucky I had that 'for \$24 ring [city of origin] as much as you like for a month' and sometimes I was ringing like every day because I just wanted to talk to them but we are used to it now.

INT: *While you were in the study you weren't doing all that well?*

*No, because I hadn't been up here very long. I was feeling quite isolated.
(66, female)*

...I have come to the conclusion that I was suffering from a degree of depression at that period I left home and got to Auckland. I had no social network up there at the time. I was boarding rather than flatting. I was an eighteen year old, fundamentally lonely I suppose for those first few months and yeah, there was a period, I can't recall exactly how long, it wasn't that long, perhaps three months, that as I look back on it, life was pretty dark outside of work. (24, male)

Much of the literature on relocating encompasses elderly residents relocating to care homes for which the detrimental effects can include depression (e.g. Castle, 2005). Rossen and Knafi (2007) found that success of relocation for the elderly was dependent upon the individual's level of self-esteem, depression, and quality of life prior to the move.

Additional relocation research often focuses on the necessity to move after a disaster (e.g. Goto, Wilson, Kahana, & Slane, 2006; Najarian, Goenjian, Pelcovitz, Mandel, & Najarian, 2001). Depression and PTSD were common consequences of psychological adjustment after such a move.

According to Puskar and Ladely (1992), 18% of their sample of adolescent girls aged 14-16 years who had moved within the past 3-18 months suffered clinical depression and 18% suffered anxiety to some degree. The most common coping strategy employed was escape-avoidance.

Although the feelings of loss might be greater for the elderly and for those who relocate after disaster strikes, the current research confirms that relocating for adolescents and adults causes some level of distress and can lead to symptoms of depression.

Employment

Many of the participants left employment over the years for various reasons. Five individuals (4 males, 1 female) lost their jobs through termination or illness. Most were listed as significant memories in the PHQ-F, with no further information regarding a relationship between job loss and depression or how it affected them in other ways.

Losing a job, particularly through being laid off or illness rather than voluntarily resigning is known to increase distress. Financial concerns alone from such a loss cause much distress. A survey titled “The Anguish of Unemployment” (Rutgers, The State University of New Jersey, 2009) uncovered rates of depression through job loss at 68%. Sixty five percent of recipients ($n = 894$) reported feeling anxious and 77% reported feeling stressed. Furthermore, 32% concluded that their unemployment caused stress within their relationships with family or friends. Unemployment was found to have the strongest correlation to depression when comparing national surveys of mental health and well-being (Wilhelm, Parker, Geerligs, & Wedgwood, 2008).

One participant attributed stress from increased workload to be the reason for his leaving work and his depression.

There was so much negativity and I mean, a lot of the rest of the staff felt the same either, I wasn't unique in having those opinions. You know, eventually I feel that thirteen or fourteen years just kind of caught up with me. The work load was steadily increasing throughout. At the stage I fell over, I was replaced by, depending on who you spoke to, between three and four people. (24, male)

According to Lazarus and Folkman (1984), how an individual copes with an increase in stress relates to their subjective experience. The above participant discussed increases in communication such as constant phone calls and emails as problematic. Workplace stress has increased with the increase of cyber communications (Rosen, 2008). An older person like the above participant who was not socialized to cyber communications at a young age could be expected to cope with it differently than a younger person who has grown up with such communications. A recent study conducted in China found a direct relationship between the increase of exposure to work-related stressors and higher levels of depression (Wei-Qing, Oi-Ling, Jia-Fang, Cooper, & Phillips, 2009).

The consequences of all of these types of losses could be viewed as grieving, adjustment, anxiety, or depression. Yet the majority of the participants have only had a diagnosis of depression. Furthermore, the only loss considered in the DSM-IV-TR for depression is bereavement (APA, 2000). However, participants appeared to grieve for more than the death of a loved one including loss of familiar surroundings, loss of support, loss of a relationship, and loss of employment. Some suffered multiple losses.

Stress at School including Bullying

School was commonly cited as a source of stress. Many participants hated school, one to the point of high anxiety every Sunday at the thought of school the next day. Feeling like the odd one out and being bullied at school were problems common to most of the participants.

Hated School

Half of the participants described hating school. Four participants described feeling like they were the odd one out at school. For example:

Horrible! I always felt like I was the odd one out. (56, female)

I wasn't in the 'in' crowd. I apparently came from the wrong part of town and I was not considered 'cool'. (66, female)

I didn't feel like I fitted in really. I was pretty shy and really, I don't know, maybe I hadn't really worked out how to get on with people... (33, male)

This last participant hated school to the point of feeling anxious every Sunday night about going.

I hated it. I remember Sunday nights. Eventually we got a TV and Sunday nights, we usually had Sunday night tea which was like an omelet or something, lots of people do or seem to do and so there would be the smell of toast and the Disneyland music would come on TV and I would just get this sinking feeling and it was back to school the next day. I used to hate the end of the holidays and stuff. We were all like that. It never occurred to me that people actually liked school but sure enough they do. I kind of feel like my life happened outside of school. (33, male)

Although the above participants did not necessarily associate hating school with their depression, feeling 'different' is not a new finding in depression research. Ridge and Ziebland (2006) found it to be a common concept in their study on the meaning of recovery following depression. The reasons for feeling different are less explored.

One explanation for some of these feelings might be bullying by exclusion or relational bullying which can lead to negative psychological outcomes (Crick & Grotpeter, 1995). The rejection felt interferes with the social connection critical throughout this time in a young person's life.

Alternatively, shyness, insecurity and not knowing how to form positive relationships could imply social anxiety or attachment histories which affect an individual's ability to form meaningful relationships with others. In their study of the associations between peer victimization, depression, and social phobia in

adolescents, Ranta, Kaltiala-Heino, Pelkonen, and Marttunen (2009) found that overt and covert peer victimization were associated with social phobia rather than depression.

Clinically, these findings plus previous research reiterate the importance of assessing individual experience in order to identify history which might affect the child's school experience, how the child forms and maintains relationships, the existence of any social anxieties, and what coping strategies the child employs.

Bullied

All of the participants who described hating school had talked about being bullied at school although only one specifically labelled bullying as the reason for hating school.

Nine of the 13 participants were bullied at school. Being bullied can result in psychopathology including anxiety and depression which can continue into adulthood (Bond et al., 2001; Fekkes et al., 2006; Gervay, 2007; Fight Crime: Invest in Kids, 2003; Kumpulainen et al., 2001; Smokowski & Kopasz, 2005; Sourander et al., 2000).

For some of the participants the stress was not discussed as being long lasting. Maxwell and Carroll-Lind (1997) confirmed that some effects can be short term. However, they note that most adults will remember childhood victimization regardless of the duration. The following male participants noted that they were bullied but they were able to stick up for themselves or learned to ignore it.

Oh, a little bit but then again, it depends on what you say bullied. I was certainly insulted when I was at primary school. That's why when I look at people rewriting New Zealand's race relations history these days I know it's crap.

INT: *Right. So there were racial issues that came up in the teasing and things?*
Oh for sure. I mean, but you know, as I said, I was at a verbal ascendancy that used to put people off. They left me alone and I stuck up for myself but

you know, back in those days, unfortunately, Maoris didn't stick up for themselves and I found myself sticking up for them as well and there were a couple of run ins. (1, male)

INT: *So how did you feel when the bullying was happening to you?*

Oh, a bit pissed off and all the rest of it. Probably a bit more than that too but yeah, after a while, you just don't take notice of it. Well you do but you don't react to it. (21, male)

Although the above participant learned not to “take notice of it”, he identified bullying as the stressor that began his first depression.

INT: *So can I just check with you, when did you first experience depression, how old were you?*

That's a good question. Probably fairly young. Probably, probably just before or just after I started primary school maybe. Just when the bullying started.

INT: *So you think that it was tied up with the bullying or were there other things going on for you?*

I would say so but you probably put it down to background problems as well like, walking, talking, all that type of stuff. (21, male)

The above participant's perception was that the effects were short term. However, he considered bullying to be the cause of his first depression, indicating serious consequences. Additionally, the clear memory of the stress and depression felt at the time could indicate longer lasting effects than implied, especially since he had continued to suffer depression into adulthood.

Others managed to divert the bullies or avoid them by retreating to safe places such as the library as with the following female participants.

INT: *So was finding the library a good thing because you got to read a lot or a good thing because you got to get away from the bullies?*

Good thing because I got away from the bullies because they wouldn't go in there because it's not a cool place to go. You can quite successfully hide in the library and I like books. (66, female)

I had some awful nicknames in that patch of time as well and the only solace I got was from being in the library and being a librarian because they were the only group of people that were nice to me (laughs). (69, female)

Such avoidance might have reduced the incidence of being bullied but not necessarily the psychological consequences. The above participants do not discuss possible consequences in terms of psychological outfall. However, this type of avoidant coping was found to be related to anxiety in a study by Vierhaus and Lohaus (2009). They also found that anxious individuals were more likely to seek social support and use palliative coping. The avoidance for the above participants could have reduced the likelihood of the participants learning effective coping strategies to help them in other stressful times of life.

Bullying was described in various ways:

Oh I used to get picked on. Used to have my lunch taken off me. (12, male)

I was certainly insulted when I was at primary school. That's why when I look at people rewriting New Zealand's race relations history these days I know it's crap. (1, male)

I remember a bully was sitting next to me once and all he did the whole time was nudge me with his elbow and I put my hand up and the teacher said

“Don’t tell tales.” So I remember one day he had his hand here and I got so sick of him I stuck a compass through his finger. (6, male)

...a girl who wanted my best friend for her friend and she did anything she could to stop my friend H and I being friends which is rather ironic seeing H and I are still friends. (66, female)

For a few the bullying was a source of anger as with (21, male) who was “a bit pissed off and all the rest of it”. All except one of the bullied participants reported feelings of anger during their lifetime, and all except one of the participants reporting feelings of anger had been bullied, suggesting an association between anger and being bullied.

Most research more often discusses the relationship between aggression and bullying (e.g. Camodeca & Goossens, 2005; Glew et al., 2000). Previous research that specifically studied anger in relation to bullying included its relationship to aggression (Camodeca, Goossens, Schuengel, & Terwogt, 2003). They considered anger to be typical of reactively aggressive children and that their anger is the result of blaming others for exploitative and/or conflictive behaviour towards them. Many of the participants were resentful and blaming towards others in various situations which could support this theory. However, the current participants were not aggressive.

Camodeca and Goossens (2005) considered the perspective that victims’ and bullies’ anger might be the consequence of a “hot-headed temperament” (p. 194) alluding to anger leading to the blaming behaviour and that aggression was the chosen goal. Additionally, Champion and Clay (2007) found that children who were more frequently victimized tended to respond to provocation with more intense anger and more desire to be aggressive.

Whilst anger was clear in this group, aggression beyond sibling conflict was not. Again, this could be underreporting of aggressive behaviour due to blaming others. Further research is required to enable conclusions beyond the identified association.

Apparent from this study is that anger continues to be present in the next generation of victims as revealed by the following participant who recognized anger in children in his classrooms as similar to the anger he felt as a child.

because when you're bullied you do get a lot of anger and I have kids in my class who are bullied at school and they have so much anger and it reminds me so much of me. (6, male)

Furthermore, anger appeared to be present in the parents of some of the participants, in particular fathers who had been described as angry or reactive. This could imply learned behaviour or anger as a result of early attachment problems.

Learning Difficulties

Four of the participants described specific difficulties with learning at school. One was moved forward a year during the year and struggled with going from the top of the class to the bottom of the next year subsequently developing a stammer. The other three described actual learning difficulties, some of which were listed in their PHQ-F. The following participant discussed his learning difficulty and how it affected the way he was treated by his mother.

Well I was unconfident in my work so I couldn't do my work properly. I was a slow reader and of course, my mother especially, was one of these persons, if you can't, if the child can't read or you are lacking like that, then, because see, when she was young and my brother was born, he got quite spoilt and of course, she took him to a doctor and the doctor says "Oh, he's spoilt. Give him a few more hidings" so everything was around discipline like that so if I was lacking in my work and I was playing up then a hiding was issued you see and like, I remember I was in the headmistress' class and I was quite behind in my reading and they had a meeting one day and I remember, I was sitting there, perfectly, the teacher was saying, you

know, “He’s behind in this and behind this. He doesn’t like this, he won’t do that” and she says “Fine, give him a hiding” and I used to get that quite a bit. (6, male)

Learning difficulties have been associated with psychopathology including depression and anxiety (Koulopoulou, 2010; Missaoui et al., 2010). However, it is clear from the above participant’s conversation that, as well as or because of his learning difficulty, other aspects of his life likely impacted on him psychologically.

Furthermore, learning difficulties have been correlated with being bullied (Sharp & Thompson, 1992). A number of children in Sharp and Thompson’s (1992) study reported that they had difficulty concentrating because of bullying, had disturbed sleep, and were often truant from school in order to avoid being bullied. All except one of the participants with learning difficulties in this study had been bullied at school. Research in this area is conflicted and inconclusive. Kaukiainen et al. (2002) found that children with learning difficulties were significantly associated with being the bully. On the other hand, they found no relation to victims of bullying and learning disorders. Conversely, Nabuzoka (2003) reported that teachers and peers indicated a relationship between learning difficulties, victimization and shy behaviour. Only one of the participants with learning difficulties in this study reported being bullied and being the bully. He also discussed having anger. The remainder described themselves as victims of bullies. This could be underreporting of bullying behaviour or bullying behaviour not being recognised as such. The majority of these participants were blaming of others and this could extend to bullying behaviour.

According to Missaoui et al. (2010), 69% of children with learning disabilities in their study had some sort of mental illness. Depression was experienced by 1.8% and anxiety 19%. Anxiety rates have been reported here as all participants in the current study experienced symptoms of anxiety as well as depression. Koulopoulou (2010) found higher self-report rates of both disorders (22.1% depression; 32.3% anxiety) and included anger at 21.6%. Of the

participants in this study who reported learning difficulties, half of them experienced anger. Additional to self-report measures were parental measures reporting parents' perceived rates of mental disorders in their children. Depression and anxiety were each reported at 21.4% indicating a tendency for parents to underestimate psychopathology in their children, particularly anxiety. Such underestimation possibly extends to other significant adults such as teachers and care givers. Furthermore, the anxiety felt by these children might manifest in other ways. For example, bad behaviour such as acting out and being rebellious, being withdrawn, quiet and shy.

Anxiety

Although not necessarily recognised as such by the participants, all described symptoms of anxiety. This was evidenced in their descriptions of symptoms associated with anxiety including the discomfort being around people described under the heading *Bullied* and uncontrollable worry, as well as the use of avoidant coping styles.

The following participant identified anxiety as the source of his depression and that the anxiety stemmed from worry about possible trouble, the worry alone being quite traumatic for him.

INT: *But it was a worry for you?*

Oh it was a worry and I think that's where the anxieties all started from.

INT: *Okay. So can you remember what that felt like, how it was going on for you?*

Oh it was shocking. I would get up in the morning and really, my stomach would be churning. I just did not want to go to school because I didn't know what was going to happen. This was secondary school and I mean we're talking thirteen or fourteen now and, you know, every night there would be cases in the paper. They wouldn't do it today...!

INT: *Yes. So what, when you say that's when you think depression started, was it depression or was it anxiety?*

It was anxiety really, wasn't it? Yeah, it was anxiety and then, I mean, I wondered whether that was the start of it because I would get up in the morning and I would worry about this and go all day and nothing would happen and then so you would sort of go up to a bit of a peak and come down and down and down and get home and then you would read the paper and see, 'oh, he's in court'. Away you would go up to this level and then down and then get up in the morning and you know and it was doing this all the time. (11, male)

For the above participant, his perceived lack of control and the unpredictability of the situation impacted on his stress levels daily producing a cumulative effect. As discussed in the literature review, uncontrollability and unpredictability have been identified as core components of stress (Cohen et al., 1983).

Worry

Worry was a common problem for almost half of this group. Some of the worry was perceived as a real threat as with the first of the following participants. Others recognised that they worried over almost anything and had difficulty not doing so which is the main feature of GAD (APA, 2000).

When people talk about what Mum went through, they call it a mental breakdown and although we know there was of course, another underlying condition now, there was always that feeling that I'm fairly much like her in a lot of respects, am I going to have the same thing and I remember thinking 'oh God, I'm going to fall apart' when I got told I had depression, you know, I'm not going to be a functioning member of society. I'm going to end up sitting in a mental ward huddled in a corner. (82, female)

Depends what's going on. I get anxious about just almost anything. (21, male)

I can remember my mother making the comment “You’re the kind of person who worries about something that if he didn’t have anything to worry about you would worry about that.” You know, so I guess I’ve always had that tendency so. (1, male)

Irrational Fear

Related to worry is an irrational fear. The majority of the participants discussed being scared or fearful at times, some more than others. For some the fear could be regarded as rational, a fear that was instilled by actions of others or being frightened at the time of an event, for example:

...being told, “Well, you are going to go crazy. You are going to end up in Porirua” and that was really, really scary. (56, female)

...by the end of the year [6th form] I was on anti-depressants for the first time which was a rather scary experience I have to say. (66, female)

For others, the fear had become less rational or was consumed in being frightened about future unknown outcomes.

I used to sum it up to my counsellors that I was scared of myself. I was scared of what I couldn’t do, not what I could do because when you have all that negative feedback you become negative. (6, male)

I just used to get quite depressed but I was frightened about being on my own because I didn’t have anybody in New Zealand. I didn’t have any, well, I had friends, I had really good friends but I didn’t want to live on my own because I had not even spent a night on my own before. (67, female)

Avoidance

As well as the worrying and fears of these participants, avoidance was the most common coping strategy employed by this group. As discussed earlier under *Bullied*, avoidant coping was found to be related to anxiety (Vierhaus & Lohaus, 2009). Participants typically referred to it as avoidance rather than diminished interest which is more commonly associated with depression (APA, 2000).

Anxiety Symptoms

For some participants the symptoms were more specific such as PTSD symptoms, panic attacks, agoraphobia, and social anxiety. Examples of the more specific anxieties include:

Not too good. You can't really help thinking about it. It's just like, what do they call it, um, post traumatic stress. Ten years down the track so I mean, that's quite interesting. (21, male)

...and I went to a stage of real panic attacks. I was scared to go outside. Couldn't go and do the basics like the grocery shopping... (56, female)

INT: *You mentioned that you developed agoraphobia at a point. When did that come on?*

That came on about, came on about 1990, end of 1990 and I think it was just after I broke up with her and it really didn't stop properly until about '94, '95, after I had met my wife. (6, male)

Further symptoms common to anxiety amongst this group included an inability to relax (24, male), nervousness (67, female), paranoia (6, male, 69, female), hyper vigilance (6 & 21, males), perfectionism (1, male), poor concentration (18, male), poor sleep (6, male), not eating (66, female), feeling out of control (33, male), being rebellious (1, 6, & 24, males, 56 female), over

analysis (1 & 21, males, 82, female), and diarrhea from irritable bowel syndrome (69, female). For example:

Yeah. One of my counsellors from a while ago, in her notes put something about heightened level or increased, heightened, increased level of hyper vigilance. Yeah.

INT: *And were you aware at the time that you were, you know, that you were being sort of hyper vigilant?*

Oh hell yeah. Yeah. Yeah. I still get hyper vigilant at the moment. Yeah. (21, male)

Yeah, I went to the doctors in the end. I went to the doctors because I had diarrhea all the time and she, I had a little operation where they look down your stomach with a camera. What's it called?

INT: *Oh, yeah, gastroscopy.*

Yeah. And they said that they couldn't see anything wrong and it was irritable bowel. I went to the doctor and doctor gave me some anti-depressants and some counselling. (67, female)

Granek's (2006) research with depressed Canadian students found similar symptoms: a discomfort being around other people, being anxious and agitated in public, feeling a knot in the stomach, nervousness, and anger. She suggested that further experiential studies were required to gain a deeper understanding of depression. However, the majority of the symptoms relating to her participants, as with my participants could be considered anxiety.

Wilhelm et al. (2008) reported from their longitudinal study of women that early onset anxiety disorders were an indicator of early onset depression and recurring episodes. Of those who reported a lifetime history of anxiety, 70% had experienced the onset of anxiety before their onset of depression. They suggested the treatment of the anxiety disorder to reduce the recurrence of depression.

Because a highly anxious personality trait had been identified as a risk factor for depression, Sandi and Richter-Levin (2009) proposed a neuro-cognitive model that suggested the importance of developing a prevention programme aimed at helping individuals cope with stress and prevent the dysfunctional cognitive decline. Results from the current study indicate that a programme such as that proposed might have been beneficial for these participants.

Indicators of Anxiety

Further indicators of anxiety are the emotions and apparent reactions. These were varied amongst the participants but most common were anger and rebellion, insecurity and guilt.

Half of the participants discussed anger as having been problematic. The second participant, in particular, noted the long-term effects his anger had on him.

INT: *Right. You've told me you've had quite substantial troubles with managing anger, you know, since you've gone through life. Was that, do you see connections?*

Oh yeah, every day. I think every day, if I was as strong now as I was then that I would kick the living hell out of some of these punks at school... (6, male)

I've finally lost the bitterness and anger which took an awful lot of shaking off. It was actually sort of crippling me really. (24, male)

Anger with regard to bullying has been discussed under the heading *Bullied*.

Many studies regarding anger and stress/anxiety were in relation to PTSD (e.g. Dyer et al., 2009; Meffert et al., 2008; Olatunji, Ciesielski, & Tolin, 2010). However, Siew et al. (2005) found that anger was directly related to stress. More specifically, higher levels of anger were directly related to higher levels of stress and lower levels of support, and indirectly to the use of avoidant coping, resulting in greater psychological distress.

With regard to PTSD and anger, Meffert et al., (2008) confirmed a correlation; that is, that trait anger indicated a higher risk of PTSD symptoms, and that PTSD symptoms likely increased state anger. Olatunji et al. (2010) extended their study beyond PTSD alone and concluded that higher levels of anger were found amongst all anxiety disorder patients compared to a control group, and that patients with PTSD showed significantly more difficulty with anger than all other anxiety disorders. Interestingly, all participants in the current research who showed signs of anger also showed signs of anxiety. However, the one participant who specifically described symptoms of PTSD did not discuss being angry or show signs of anger.

Two recent studies found anger to be associated with coping styles (Arslan, 2010; Vierhaus & Lohaus, 2009). Coping styles will be discussed in more depth under the theme *Maintaining/Unhelpful Factors*.

Possibly associated with anger is the propensity to be rebellious which some of this group discussed being. For example:

I was twelve when we shifted location. I would have been a wee bit older than that when I started, would have been two years older than that when I started drinking beer and smoking cigarettes. It was a mild form of rebellion actually. A mild and self destructive form of rebellion. (24, male)

It would be the things like the housework and the things that I dislike doing and I think too, that could be a form of rebellion because everything had to be ordered at home. (56, female)

Participant 24 (male), in particular, described the negative effects of his rebelliousness in terms of being self destructive. However, any consequences for participant 56 (female) are unclear. There is a paucity of literature on the relationship between anger and being rebellious. Most focuses on political rebellious acts for which anger was a driving force (e.g. Heilman, 2010). Of the

participants who described some form of rebellion, only half also discussed feelings of anger indicating no strong association.

Apparent in the above examples, in particular participant 56 (female) is that rebellion was implemented when she felt that she had no control. Lack of control has arisen in past discussion and was referred back to Cohen et al. (1983) who link the feeling of an individual's life being uncontrollable to perceived levels of stress.

Insecurity

A further common factor amongst this group was feelings of insecurity, with almost half the participants acknowledging such feelings. Some talked directly about feeling insecure like the following examples, while others described it as pleasing people in an attempt to keep them happy or needing to be liked.

I think I was very insecure about moving out. I had, and still have to a degree but not as much, I had a great fear of change. Even when Mum and I moved house it was really hard. Really, really. (6, male)

I have a few memories of being a bit insecure at school, right through school until I hit fifteen. (laughs) (69, female)

The psychological stress is clearly described by the first participant. However, participant 69 (female) talks of mild insecurity without expanding on the psychological outfall.

Studies on insecurity tend to relate to specific insecurities. Common was job insecurity (e.g. Gaunt & Benjamin, 2007) and food insecurity (e.g. Drimie & Casale, 2009). One study found that insecurity revealed by the AAI correlated to higher levels of self-reported psychopathology for individuals who were experiencing high levels of life stressors (Fortuna & Roisman, 2008). They also found that avoidance and anxiety correlated strongly with psychological distress regardless of whether life stressors were considered to be high or low.

Guilt

A smaller group of people had feelings of guilt which they continued to keep hold of and discussed in terms of how it continued to affect their lives.

Yeah. Yeah, guilty. Yeah. Very guilty. Not living up to expectations and also, I think even at that age I had an expectation, I had been told that I should be able to do it so I felt like I had let myself down. (1, male)

I don't know because like, probably feeling guilty that I couldn't have like, stop the crash even though it was like, from like this wall to that wall away, yeah. I saw him coming around the corner but there was no time to like, get to him before the truck got him. (21, male)

...sort of a horrible feeling of there should be a duty there and only dealing with her as a duty. (56, female)

Research on guilt provides mixed results. Guilt was an accepted feature of depression and correlated highly with the exception of moral standards according to Ghatavi, Nicolson, MacDonald, Osher, and Levitt, (2002). Guilt was also significantly associated with depression in a sample of adolescents who had terminated a pregnancy (Ely, Flaherty, & Cuddeback, 2010). However, Webb, Heisler, Call, Chickering, and Colburn (2007) found no such correlation in their sample with a history of maltreatment. They found that shame had a strong correlation to psychopathology but guilt did not. It would seem that the feelings of guilt and the effect it has is dependent on the individual's specific life experience, reiterating the importance of exploring individual life experience when assessing and treating depression.

Much of the literature, again relates to PTSD (e.g. Kletter, Weems, & Carrion, 2009; Marx et al., 2010; Robinaugh & McNally, 2010; Wilson, Drozdek, & Turkovic, 2006). Participant 21 (male) described his feelings of guilt with

regard to a crash he witnessed that killed his friend. He also described symptoms of and had been diagnosed with PTSD after this incident. The other participants however, did not describe PTSD symptoms.

Results of the current study highlight the importance of teasing out the individual experiences of anyone presenting with depression. Many of the descriptions and symptoms discussed by the participants are indicative of anxiety disorders. Should it become clear that anxiety symptoms preceded the depressive disorder and coping strategies indicate coping typical of anxiety, it would be pertinent to treat the anxiety disorder while monitoring depressive symptoms.

Although previous studies have questioned the financial and time implications of offering resilience-building/anxiety-prevention programmes in schools such as the “Friends for Life” programme (Rose, Miller, & Martinez, 2009), further research needs to compare the cost of such programmes in schools to the cost to individual adult lives and society in time and finances for not having such programmes. Rose et al.’s (2009) study confirmed that all children benefited from some form of prevention. It is clear that most of the participants’ distress began at an early age and most employed ineffective coping strategies. The school setting captures a vast majority of children and could be used to teach other valuable life skills beyond reading, writing and arithmetic.

Summary

Discussion and symptoms of stress and anxiety were prevalent throughout the interviews and the PHQs. Stressors were varied and included such things as being bullied, exam stress, relationship problems, loss, and work stress. Not all participants were able to label a specific stressor but perceived that stress was a cause of their depression.

Relationships were a common cause of much distress. Dissolved marriages were identified as the cause of depression for two participants. Previous research identified problematic relationships as being correlated with depression. Problems varied across cultures but isolation and loneliness were common consequences

across cultures. Research regarding relationships and depression highlight the importance of considering culture within the individual experience of depression.

Most of the participants had suffered traumatic incidents, the majority of which were in their early years, if not their first memory. Some suffered childhood illnesses. Short-term adverse effects are usually PTSD and anxiety. Long-term consequences are less known.

Some suffered multiple traumas which had a lasting effect. Each trauma impacts on the next. An individual's ability to cope depends on how well informed the child is at the time, their level of understanding, and the level of support. Support is highlighted as a key factor for coping with stress.

Loss and adjustment were common stressors for this group with all 13 being affected to varying degrees. Nearly all had suffered the loss of a family member or close friend. Many were experienced in childhood. Childhood bereavement can result in anxiety and depression. The level of support is a key factor in how the child copes. For many, loss or lack of support was a problem.

Many suffered multiple losses which they perceived contributed to their high levels of stress. Many had moved location which resulted in feelings of isolation and loneliness. Again, moving often resulted in loss of support of family and friends.

Others suffered loss of employment impacting on them financially and psychologically.

The only loss accounted for in the DSM-IV for depression is bereavement. Clearly, losses beyond bereavement need to be considered.

More than half hated school and even more discussed being bullied at school. Some felt like they did not fit in which could be the result of relational bullying or bullying by exclusion. Alternatively, blaming behaviours might exclude some participants from describing themselves as bullies.

Types of bullying varied, for example, stealing lunches, racial discrimination, poking, and relational bullying. Research suggests that being bullied can result in anxiety and depression. Even when effects are described as short term, long term psychological consequences are likely. This was highlighted

by the participant who described being bullied as the cause of his first depressive episode, and by the participants who avoided the bullies. Avoidance can lead to negative psychological consequences and is usually associated with anxiety.

Anger and bullying appears to be correlated. Further research is required regarding anger and bullying. Most research covers aggression. However, aggression was not apparent in this group.

One quarter of the participants described some form of learning difficulties at school. Anxiety and depression have been reported consequences of learning difficulties. Anxiety is reported more frequently. Parents have been found to underreport psychological disturbance in their children. Such underreporting could extend to significant others such as relations, teachers and caregivers.

There is some evidence of an association between being bullied and learning difficulties.

All of the participants displayed symptoms of anxiety. Some related more to specific anxieties such as social phobia while others were more generalized symptoms. Anxiety symptoms were varied with worry and fear being most salient. Anxiety is a contributing factor for depression.

Avoidance was the most common coping strategy employed by the participants in this research. Avoidance is usually associated with social phobia and generalized anxiety disorder.

Symptoms described in other depression research relate to anxiety and are similar to this group. Early onset anxiety disorders are predictive of early onset depression. Again, assessing individual experience is imperative. Should symptoms of anxiety precede the depressive episode, it might be pertinent to treat the anxiety disorder while monitoring the depressive symptoms.

Common feelings and behaviours pertaining to stress were anger, rebelliousness, feelings of insecurity and guilt.

Chapter 9

Negative Attachment Styles

Much research has related problems of attachment to common psychological problems including anxiety and obsessive symptoms (McBride et al., 2006), avoidant personality disorder, academic problems, and depression (Sadock & Sadock, 2007). One study found no such direct links between poor parent/child relationships and depression or anxiety (Overbeek, Stattin, Vermulst, Thao, & Engels, 2007). Although indirectly, they found that the quality of partner relationships was affected as was emotional adjustment in midlife. As discussed in Chapter 8, participants from the current research often had difficulty with partner relationships.

All participants reported aspects of how they were parented which could result in negative attachment. Some discussed how negative parenting styles contributed to their stress and depression. However, none considered parenting styles when asked about possible causes of their depression. Most described what their parents were like without relating it to their depression. Included in this theme are the sub themes *Parental Relationships*, *Sibling Relationships* and *Positive Relationships* to enable a more complete view of attachment for this group and possible flow on effects within their families.

Parental Relationships

Communication

The majority of the participants described remoteness and/or poor communication with one or both parents. Most expressed this in terms of being distant or not close rather than bad communication per se. However, the following participants recognised that communication with at least one of their parents (two for father and two for mother) was minimal or poor.

No. I never really talked to him.

INT: *You don't talk to your father?*

No.

INT: *Why's that do you think?*

I don't know. Just never have. (18, male)

... and Dad was never a very communicative person. Always made our boyfriends or girlfriends when we were growing up feel like he didn't like them. It was just because he didn't talk. He didn't know how to communicate and that was also part of it. It made it - he made it very hard for us to actually have some sort of relationship with him because he just didn't communicate. (69, female)

Not to that extreme but my Mum is the type of person who likes to please everybody and doesn't like confrontation and so I try and talk to her about something that's not just a normal problem but, you know, I'm confronting her about something and she changes the subject or just fobs it off and then changes the subject so, and I find that quite hard. (69, female)

Yeah. I remember ringing her up to say I had left my husband and instead of saying "Oh, are you okay?" she asked about the weather. That was a good conversation! Okay! Mum doesn't want to know. We will let that one sink in and you know, because I had other things to deal with. Yeah, so it's, Mum lets her disapproval be known in maybe not a verbal way but her actions often speak very much louder than her words. (82, female)

Participant 18 (male) had no further comments to make regarding how such limited communication might have affected him and he was unsure if he wanted the communication with his father changed for the future. He appeared to accept it as it is. Participant 82 (female) also had no further comments regarding how the style of communication she had with her mother might have impacted on her

mental health. However, participant 69 (female), while no further comments were made about the communication with her father, noted that she found her mother's communication style "quite hard".

The rest were described as distant or neglectful with seven participants describing this of their mother and five of their father. For example:

Well she didn't give us a lot of attention and everything had to fall around the house being nice and tidy and if she was washing the floor we had to stay outside and things like that. (laughs) (67, female)

...but I guess by modern standards you could argue we were probably neglected and I think the reason for that is the same probably my kids would say the same about me, he was so busy making ends meet and making a family of us that he didn't have time or didn't appear to have time to show a lot of affection so I believe that we were neglected from that point of view. (11, male)

Although more mothers than fathers were described in this manner, mostly fathers were excused with explanations such as being "busy making ends meet" (11, male), "working such long hours at work...he was just too tired to be dealing with us..." (66, female), "Dad didn't see us very much. He went to work and came home..." (67, female), or he simply "didn't talk" (69, female). This was not necessarily viewed as negative. It appeared to be culturally acceptable if not expected that fathers would be less involved and less communicative in the younger years.

Furthermore, considerably more relationships with fathers improved as the participants developed into adulthood than did relationships with mothers.

INT: *So what was your relationship with your father like when you were an adult?*

Oh, much better. (11, male)

Yeah, in my twenties, she's come down and I've realised that she's not as perfect as I thought she was so that's been a bit of a shock and my relationship with my Dad has improved, especially since I left home. I don't know why. (69, female)

Some male participants reported this to be the case with their father/children relationships. The improvement in relationships perhaps indicates cultural norms being more entrenched as they develop from childhood into adulthood. Such cultural acceptance indicates that, from some individuals' perspectives, the type of attachment insecurity depicted by this type of poor communication might not be the cause of their depression. That is, research from instruments such as the PBI indicating that paternal care is related to depression (e.g. Kerver et al., 1992; Parker & Manicavasagar, 1986) might miss that the participants did not perceive it as problematic. Their depression, from their perspective related to other stressors later in life.

This is not to say that insecure attachment from poor communication is not problematic. Other research from depressed adolescents' perspectives has found that parental and other adult partnerships were important (McCarthy, Downes, & Sherman, 2008).

Another recent study found similar results to mine when studying the perception of rejecting and neglectful parenting in childhood (Ehnvall et al., 2008). They found that mothers were perceived in a more negative manner by depressed females than depressed males. However, there was no difference between genders regarding the perception of fathers who were seen as less negative than mothers. They attributed this finding to differences between males and females in their processing of negative experiences and emotions. Females were more sensitive to feelings of rejection. My research suggests that such differences might be more culturally bound.

It would appear that limited relationships through poor communication leaves individuals susceptible to later stressors with limited coping skills to

navigate such stressors (Kraaij et al., 2003; Matheson et al., 2005). Highlighted is the importance of assessing communication styles in a clinical assessment, bearing in mind cultural expectations and how these might shape an individual's perspective of their communication style.

Further research would help to establish a more in-depth understanding of cultural expectations and how these might affect an individual psychologically. What is currently highlighted is that close consideration of culturally accepted norms is necessary and would aid with understanding individual experience and planning treatment pathways.

Some of the participants, in particular males, recognised a similar pattern in their own parenting without necessarily considering it negative, reinforcing cultural acceptance. This type of pattern would be expected as problems of attachment include the inability to be good parents themselves (Rikhye et al., 2008; Stroebe, 2002). Accepting it as a cultural norm rather than negative attachment to be addressed ensures a continued pattern.

Conflict

Conflicted relationships between participants and their parents were apparent in the interviews as well as listed in their PHQ as being problematic for most of the participants. They appeared to begin at an earlier age with almost half of the participants stating that they had conflicted relationships with their parents between the ages of 11 and 15.

Fathers were mostly discussed in terms of him being grumpy or fiery, and mothers were mostly described as being hard on kids, judgmental, manipulative or biased. The balance was with regard to parents in general. When asked in the PHQ-F to describe the atmosphere at home when they were young almost half of this group described a tense atmosphere. Following are examples of conflict causing tension.

Oh, physically, not physically safe. I mean because he actually raised his fist once and I said "I will have you arrested" you know. (6, male)

It was a bit stormy with my Dad when I grew up. (69, female)

I can remember having some horrendous fights and then the promise was made, if you do a trade we will let you go farming so I did my trade and when I came out of my time I still wasn't allowed to go farming. (11, male)

Conflict is poor communication but in a different form than already discussed. Conflict was not described by participants in a way that could be viewed as culturally acceptable. However, the conflicted relationships also improved as the participants got older, indicating that more than cultural expectations were involved in perceptions of improved relationships.

Whilst there is an abundance of literature on attachment styles and their relationship to depression (e.g. Lancaster et al., 2007; Liu, 2006; McBride et al. 2006; Oakley-Browne et al., 1995; Rikhye et al., 2008; Wei & Ku, 2007), there is less literature documenting communication styles within families and how they relate to the development of psychological distress.

Conflict was found to predict depressed mood and anger for both genders in a study by Sigfusdottir and Silver (2009). They found conflict to be a stronger predictor of depressed mood and anger than negative life events. However, although anger was identified in half of my participants, only three of the angry participants considered their relationship with one or both parents to be conflicted. Anger appeared to be more closely related to anxiety or being bullied for this group of participants.

Research conducted by Heene, Buysse, and van Oost (2007) found that a conflicted communication style within a marriage led to poor marital adjustment and depressive symptoms. Additionally, *Conflictive-type* participants displayed the highest levels of depression, post-traumatic stress symptoms, and state-trait anxiety in research with cancer survivors (Ozono et al., 2010). Although studying differing groups of individuals, it could be expected from such results that my

participants living with conflicted relationships would display symptoms of depression at some stage.

As discussed in the literature review, research is inconclusive as to how important each parent is to the development of secure or insecure attachments and subsequent psychopathology. There was little difference in numbers between mothers and fathers found in my research. More apparent were the different styles of communication described and the clearer acceptance of fathers' poor communication compared to mothers'.

Certainly, parent/child conflict and poor communication between parents and children are indicative of problematic social-emotional development into adulthood, and are likely to predict challenging adult partner relationships (Overbeek et al., 2007). Problematic adult partner relationships were discussed in the theme Stress and anxiety – Causes and Consequences and clearly were a problem for many participants. Highlighted is the need for further research on differing communication styles within families and the psychological outfall. This should include personality styles and behaviour of the children to avoid the propensity to blame the parents alone. Parenting styles have been found to be a consequence of a child's behavioural issues (Kerr, Stattin, Biesecker, & Ferrer-Wreder, 2003).

Clinically, the current research highlights the necessity to investigate communication styles as well as social and cultural expectations when assessing and treating individuals with depression.

Overprotected

Almost half of the participants perceived their parents as having been overprotective.

Some discussed this without directly attributing this to causing their depression, for example:

Yeah, sometimes like when you wanted to go out and they would say no.

INT: *Did that crop up more as you got older?*

Yeah. Over protective.

INT: *Over protective a bit?*

Yep.

INT: *Okay. So what was that like for you?*

Dad was more over protective than Mum. (21, male)

Others made a connection between being overprotected and the negative effect this had as with the following participants:

INT: *So your Mum was quite protective of you. Do you think that has had an influence on your history with depression?*

Yes I'm sure it has.

INT: *Okay. In what ways do you think that might be?*

Because when you are in your formative years doing those things are part of growing up and you're forming your own personality but if they are suppressed, physical or mentally, then you don't develop them and so therefore I believe it has an effect on my total overall depression. (11, male)

Oh because I was a soft touch. Because I was mollycoddled at home. I mean, I wasn't a small kid. The bullies were, I'm doing a parenthesis sign, in gangs and perhaps half a dozen. It was six to one. I mean, physically you couldn't, I mean, even a tough kid would be hard pressed to overcome them. It was certainly a desire on the part of the bullies to dominate and I was a subject that wasn't too difficult to dominate at the time I think. (24, male)

Participant 11 (male) discussed his negative effects in terms of emotional development. Participant 24 (male) discussed his in relation to him being bullied. According to Smokowski and Kopasz (2005), one consequence of overprotective parenting is the propensity to be bullied. As discussed in the previous chapter

under *Bullied*, the majority of bullied participants perceived one or both parents as being overprotective, supporting this theory.

Research connecting overprotection with depression was less conclusive. Overprotection has been linked to depression (e.g. Parker, 1979; Rikhye et al. 2008) but such studies couple overprotection with low care. Parker (1979) found only a weak association with overprotection in his non-clinical group. High maternal overprotection was associated with poor antidepressant (fluoxetine and nortriptyline) treatment response (Johnstone et al., 2009).

With previous research in mind, the current qualitative enquiry suggests that depressive symptoms were more likely the consequence of stress and being bullied at school, and that overprotective parenting was a contributing factor. However, further research would help to establish to what extent overprotective parenting contributed to stress and/or depressive symptoms in children prior to the obvious stress at school.

A consequence of being overprotected is dependency (Blatt, 2004, as cited in Marshall, Zuroff, McBride, & Bagby, 2008). Almost half of the participants were dependent to some degree, most on their parents and a smaller number on their spouse. Most acknowledged their dependency along with the negative consequences. The first of the following examples is the only participant who described what the researcher deemed to be a dependent relationship but did not acknowledge it as such. The balance articulated the consequences of their dependency.

We lived with my parents for about eighteen months which was quite interesting. There was us, my sister and [husband] and I and so we lived at Mum and Dad's and...and when Mum and Dad bought our house for us last year we went with them to the bank, to the lawyers and were totally involved with it so it's really good. (66, female)

But I had been living at home, I was pretty, I hadn't done anything for myself. I couldn't even use a washing machine or, Mum used to do everything, or cook. (67, female)

INT: *Okay. You've also sort of noted that you felt he tried to make you dependent on him and that you couldn't look after yourself, those sorts of things.*

Because he would say "Oh, you can't do that. You're no good for anything" you know. He would say "Oh, you'll never do that".

INT: *So how did you feel about that and what did you do when that happened?*

...Well I think it made me feel very untrusting, very lacking in confidence in myself. In the end I just couldn't ask him anything. Couldn't speak to him. He would do all the talking, you know. He would speak for you but when you spoke for someone else, he would tell you to shut up. (6, male)

Participants 67 (female) and 6 (male) discussed their dependency and resulting negative consequences in terms of skills lacking or feelings such as the inability to trust and lacking in confidence rather than resulting in their depression per se. However, past research has found an association between dependency and depression (Cogswell, Alloy, & Spasojevic, 2006; Luyten et al., 2007). Furthermore, Marshall et al., (2008) found that dependency in individuals predicted poorer treatment outcome in a trial using CBT. This finding was a trend rather than a significant finding and further research is required to replicate this finding. However, it highlights the difficulty clinicians may have in treating depression in an individual with dependent traits.

Parental Psychiatric Illness

The majority of the participants had one parent who they described as having had mental health problems including problematic alcohol use. Unlike Wilhelm, Roy, Mitchell, Brownhill, & Parker (2002) who reported that women were nearly three times more likely to report a mental illness in their family, no such gender differences were apparent in this study.

Two participants described both parents as having mental health problems. One had a father with a head injury and depression and mother with schizophrenia and depression (18, male). The other had a father who was an alcoholic and mother whose illness was not named (56, female).

Less than half of the participants described their father as having had a mental illness with three having had depression. For example:

In fact since I've gone through the whole depression thing because Dad went through it too, Dad understands probably a bit more because he actually went through it himself and still has patches when he's like that... (69, female)

Ah, yes, yeah, in his earlier years he drank every day. He would go to the pub after work.... it was Christmas Eve day; he would come home completely sozzled. You know, he would come home sozzled. There were many an argument Christmas Eve.... (12, male)

Participant 69 (female) discussed the positive experience related to her father's depression in terms of his ability to understand what it was like for her. However, participant 12 (male) noted the arguments created because of his father's alcohol dependence causing stress.

More than half of the participants described their mother as having had a mental illness. Four reported a breakdown and four had depression. Mothers also had a wider variety of mental health problems mentioned. Examples are anxiety, schizophrenia, hypochondria and Alzheimer's disease.

Yeah [depression], most of her life really... when my brother was born ten years later she did exactly the same thing. She had another bad breakdown and was taken away again. (11, male)

Mum was a shocking hypochondriac, about as, I don't know whether hypochondria is a psychological condition as such but I mean, she would probably be about as serious as you could get and she was convinced that she had septicemia ad infinitum if you please. Didn't sort of realise that she would have been dead within a fortnight had she had septicemia that went untreated and she was obsessed with health issues.

INT: *With your health as well as hers?*

Yeah. Yeah, like particularly with her own but she assumed that those close to her, I suppose me in particular more so than Dad, were also suffering from some sort of ill health malaise. (24, male)

Again, the first quote from participant 11 (male) does not discuss negative consequences to him at the time. However, participant 24 (male) noted that his mother's hypochondrias meant that he was often told that he was suffering "some sort of ill health malaise". He described this as resulting in being overprotected with the consequence of being bullied when younger, and retreating from his mother as he got older to the point of having very little relationship with her.

It is widely acknowledged through family, twin, adoption, and linkage studies that individuals with parents who have experienced depression are more prone to having depression themselves (Sadock & Sadock, 2007). Whilst genetics may have some influence, other factors such as having a parent with a mental illness impacting on the attachment of the child must be taken into consideration. The unpredictable behaviour and periods of separation due to hospitalization, as well as varying communication patterns expected from a parent with a mental illness causes major stress for children (Pretis & Dimova, 2008) and threatens secure attachment. In addition, some participants had underlying worries that they might end up with the mental illness suffered by their parent. One such participant's worries were exacerbated by being told by her stepmother that she would "go crazy" and "end up in Porirua" (56, female) as her biological mother had spent time there.

Should mothers be considered the most important attachment figure as suggested by Bowlby (1982; 1988), it may be relevant that these participants have a higher number of mothers with a previous mental disorder than fathers. Teti, Gelfand, Messinger, and Isabella (1995) found that maternal depression significantly impacted on attachment security in children. However, paternal as well as maternal attachment has been found to significantly predict depression in adolescents (Liu, 2006).

The levels of anxiety among mothers appeared to be as high as the numbers with depression. As with depression, those with relatives with an anxiety disorder are more prone to anxiety disorders (Sadock & Sadock, 2007).

A small number of participants described one or more siblings to have had mental health problems. One participant had a brother with depression (11, male) and another had a sister who he said “went a bit nuts” and had a suicide attempt (1, male). Another discussed a sister using anti-depressants and her brother had “issues” (67, female).

Beyond sibling relationships and sibling order, research pertaining to psychological dysfunction in siblings of siblings with a mental illness is sparse. Participants 11 (male) and 67 (female) had mothers with psychiatric problems. From familial studies such as those referred to by Sadock and Sadock (2007), siblings could be expected to have the same chance of having a mental illness themselves. Although participant 1 (male) did not report psychological disturbances in either parent, he did discuss his belief of his mother having been abused by his father.

Parental Abuse

About half of this group perceived some form of abuse, mostly from parents. Only one participant discussed having been sexually abused which was by a sibling’s friend (12, male). It could be said that sexual abuse might not be disclosed in a one-off interview. Ghanem, Hulton, Zenilman, Zimba, and Erbelding (2005) found, during a comparison of audio computer assisted self interview (ACASI)

and face to face interviews (FFI) that information of a sexual nature was under-reported in FFIs due to social desirability bias.

Non-parental abuse included verbal abuse by a relative (18, male), getting “hidings” from teachers and caregivers (6, male), being “put down” by an ex husband (67, female), and emotional abuse from an ex girlfriend (6, male).

One participant described hearing violence between his mother and father (1, male), and two participants discussed being physically abused.

I think the only other really hurtful times I used to have were with the beatings I used to get, the hidings I used to get. (6, male)

Yes he [father] was. He used to, my younger brother in particular; he used to whack him round the head all the time. My sisters, he used to give them good hidings. I have had a few hidings from him. Yeah, he was. (12, male)

The balance of the abuse was emotional with five of the participants describing having been emotionally abused. The variety of ways this was perceived included being controlled, put down, being manipulated, set up to fail, and having unpredictable parents. Although these participants did not discuss parental abuse as being directly associated with their depression, unpredictability has been linked to insecure attachment (Pretis & Dimova, 2008) and has been described as a core component of stress (Cohen et al., 1983). Insecure attachment and stress both lead to emotional and behavioural difficulties, as well psychological problems including anxiety and depression. Examples of emotional abuse include:

...even up till the time that I was engaged and that was, I would have been eighteen then, she still controlled the times that I was actually allowed to visit my fiancé. If he came into the house I would be sent to my room. I wouldn't even be allowed to talk to him and she just controlled everything sort of like the food on our plate had to be eaten whether or not we liked it, we had a set routine every day. We had to get dressed first in old clothes.

We had chores to do before school and after school. Until we were quite old we weren't allowed in the house on our own. When we did get old enough to be in the house we weren't allowed to answer the phone if she wasn't there. She basically broke off all ties from my own natural brothers and sisters, all of our memories that you have, all of our photos were destroyed. Our life started from the time that she took over. (56, female)

Oh, it was awful! Every day, every day I had to have my wits about me. When I say it was a cold atmosphere at home I practically had that twenty-four hours a day because when I went to school, all I did was get hassled, bullied, put down by teachers because I couldn't do the things properly and then when I come home I would get the same. (6, male)

You would hear the door slam. I would go to my bedroom. You would hear Dad start yelling. I would sit on my bed and start crying, you know, and in those days we had five beds in a room. They were bunks. You know, we lived in a state house and we had, the girls had three or four in a bedroom. Another bedroom had three girls in it and yeah. So, it wasn't as though you could go away and just quietly cry by yourself. (12, male)

All forms of childhood abuse, including neglect and domestic violence, have been related to severe emotional and behavioural problems (Cohen et al., 2006; Green et al., 2005). In fact, van Harmelen et al., (2010) and Liu et al., (2009) found emotional abuse predicted a higher risk of anxiety and depression, and earlier onset of depression. It would be expected then that this group of abused participants would have psychological difficulties including depression.

Witnessing violence can also result in depression and anxiety (Cohen et al., 2006). The above participant, in particular, described the emotional pain of hearing his father being violent towards his mother and older siblings. Furthermore, sharing a room with four siblings left him nowhere private to cry, compounding his grief. The other male participant also heard violence between

his father and mother. Although his mother denied it, he did not let go of his belief. Each situation might be expected to have differing levels of psychological outfall, but both would be expected to result in psychological difficulties.

Dehon and Weems (2010) suggested that inter-parental conflict resulted in maternal depression which in turn resulted in psychological problems in their children due to maladaptive parenting practices. Neither of the above-mentioned participants reported depression or any other psychiatric illness in their mother. However, participant 12's (male) father was described as an abusive alcoholic and would be expected to have a psychological impact on his mother.

Descriptions from participants in this current research indicate that witnessing alone had a psychological effect on them. Perhaps coupled with maladaptive parenting their psychological outfall might be greater.

Most of the abused participants discussed what it felt like for them at the time as a child. Some participants recognised how the abuse affected them as they developed into adulthood.

...but emotionally she [stepmother] put me backwards a lot because it was threatened, because my mother had mental problems. I can remember as a teenager being told "Well, you are going to go crazy. You are going to end up in Porirua" and that was really, really scary. (56, female)

Mostly verbally but because my parents, my grandfather had never been verbally abusive at all, I just hadn't been used to any verbal abuse at all and to me it was like worse than physical abuse. Um, just, oh, just things like simple things like him [uncle], like swearing at me and calling me a lazy so and so or saying that I'm not doing things right or just things like that. Day after day it really got to me. (18, male)

INT: *Where do you think that fear came from for you?*

Oh I think it came from when I was young. Being told I was inadequate to do things. I mean, that I was no good for doing things, that I couldn't do it.
(6, male)

Participant 56 (female) not only suffered general emotional abuse from her stepmother but had the additional worry of her biological mother's mental illness compounding her stress.

Sibling Relationships

Over half of the participants reported having conflicted relationships with their siblings. Some of this conflict was described in their PHQ-F as bullying. Most was described in the interviews as being difficult or volatile, for example:

INT: *Was your relationship with your brother always difficult or was there a time when it was ...?*

Always mostly difficult. (67, female)

My sister was living at home still but we still had a fairly moody, volatile relationship. (69, female)

Two of the participants described having had conflicted relationships with a sibling when young which had improved as they got older.

Ah [sister] and I used to bait each other. I particularly used to bait her. I was quite mean to her at times to be honest but about the time she was in the seventh form she and I started socialising together. She would come to parties with me and stuff or just hang out with me and my friends because they turned out to be the sort of people she wanted to spend time with, her peers at school so we became, yeah, a lot closer then. We were kind of close but in a spiky way whatever. We became quite close then and did a lot of stuff together. Bike trips and stuff. (33, male)

INT: *And you've got one sister. How did you get on with her when you were growing up?*

Yeah. Quite interesting really. We were normally always just about fighting but like, lately, just before and like after Dad sort of pretty good. Yeah. (21, male)

Half of the group described negative perceptions of their siblings. They were considered selfish, jealous, manipulative, spoilt, controlling, and/or overprotected. Furthermore, with the exception of one additional participant in this group, the same participants had described their parents in an emotionally abusive manner, mostly controlling.

...my sister is exceedingly manipulative, takes advantage of anybody, well, in my opinion... (1, male)

She was, I always felt too she was a bit, it was all her. Me, me, me, me, me, you know. If she got her TV program to watch, if she got what she wanted Mum to buy then she was happy. Didn't matter about anyone else. If I went without new clothes for six months she wouldn't care as long as she got hers. (6, male)

I think they were probably more positive to my sister because she has never had a depression problem... (11, male)

Of the participants who described negative perceptions of their siblings, all, with the exception of one, had described having been emotionally abused by one or both parents.

Although none of the participants in the current study accorded sibling relationships to be directly associated with their depression, Waldinger, Vaillant, and Orav (2007), found that poor sibling relationships could be a risk factor for developing depression in adulthood. They found that poor sibling relationships

and a family history of depression predicted the development of later depression. Interestingly, poor relationships with parents, after controlling for family history of depression and sibling relationships, did not predict the onset of depression in adults.

It would seem that parenting styles likely influence the quality of sibling relationships. Research in the area of attachment and sibling relationships is sparse. Cummings (1994) found that conflict within a marriage increased aggression in children. This aggression extended to sibling relationships as well as relationships outside the immediate family. Although reasons for relationship problems and divorce were not always articulated by participants, more than half who described conflict with siblings reported relationship breakdowns in adulthood. Furthermore, with the exception of two participants, those who had conflicted relationships with one or both parents also had conflicted relationships with siblings. Of the two who did not directly discuss conflict, one described her mother as “impatient” (67, female) and the other described his mother as being “hard on us” and “biased” (12, male).

Apparent in some of the participants was perceived differential parenting which has been associated with relationship stress (Rauer & Volling, 2007) and depressive symptoms, in particular differential parental conflict (Shanahan, Mchale, Crouter, & Osgood, 2008). Richmond, Stocker, and Rienks (2005) also found differential parenting to be problematic. They found that siblings who were less favoured over time showed an increase in externalizing symptoms. As well as high stress and anxiety, participant 11 (male), quoted above, had blamed overprotective maternal parenting for his depression. He perceived that he and his brother were “very much under the thumb of my mother” and his brother also suffers depression. He appeared unclear whether his sister had been treated differently. However, he made the assumption that she had been because she had not had depression.

According to Rauer and Volling (2007), it did not matter whether it was the participant or the sibling who was perceived as favoured. The outcome for the

participant was negative perceptions of the self and problematic relationships. Certainly, participant 33 (male) recognised that he had “a pretty charmed life really which makes my life even more ridiculous so yeah, I think that’s how [brother], yeah, he would see me as fortunate and fairly competent”.

Further research is warranted. However, it would seem that sibling relationships are an important consideration when assessing and treating adults with depression.

Positive Feelings

More than half of the participants reported positive feelings towards their siblings. These included being protective, being close, being supportive, and some described their relationship as “ok”. Of the participants who discussed positive aspects of their siblings, the majority had discussed negative aspects as well. However, almost half of those participants who discussed negative aspects of their siblings did not describe positive aspects. This reflects the findings between the participants and their parents discussed below.

Positive Relationships

Although this theme is reporting on negative attachment styles, it seemed pertinent to include this sub-theme on positive relationships to enable a complete discussion and comparison in parental/child interactions.

All of the participants had positive comments to make about one or both parents. Eight had positive comments about their father, such as he was protective, encouraging, supportive, and close.

INT: *Yeah. yeah. Okay. Do you perceive your relationship with your father as being a warm relationship?*

Oh very much so, yeah, no question. (24, male)

Um, he was a little bit, when he was on night shift we had to creep round the house but he used to take us to sports and stay and watch us. On a

Saturday and Sunday he used to take us down to [?] and wait because we couldn't get around. We relied on him for transport and he used to take interest in our dancing and swimming and our progression through school. He used to take interest in what we were doing and he was quite encouraging. (67, female)

Seven had positive comments about their mother, such as being close, supportive, protective, and not controlling. The majority of these participants were males.

Just virtually the same as it is now. Fairly close and you know, I tend to get on better with her than my two brothers and just seem to, I don't know, got like a bond. (18, male)

Oh great! Oh, absolute, no, no, very protective. You know, like, for example, I can't remember a day when she wasn't up before we were. You know, she was the ideal mother. She was at home when we came home. She was up before, she fed us properly. We were always properly clothed. I remember when my parents bought their first house in [city], you know, and they had nothing. We all slept on the floor but my brother and I got beds before our parents did. Now that's something I just remembered. I didn't put any significance on it at the time. I've only realised later on in life you know, that just shows where their priorities lay. (1, male)

I have always been really close with Mum. I can talk to her about most stuff. She's really good for listening and giving good advice and things. Still really close with Mum, a bit closer to Mum than I am to Dad. (66, female)

Of the participants who discussed positive aspects about their father, just two had only positive comments with no negative aspects described. Likewise, of the

participants who described negative aspects about their father, most had described positive aspects as well with only three not having done this. Similarly, of the participants who described positive aspects about their mother, all bar one had negative comments to make as well. However, half of the group who discussed negative aspects about their mother had not specifically described any positive aspects, perhaps reiterating the importance of the mother/child relationship.

Seven of the participants talked about their parents jointly in a positive manner regardless of the fact that the majority of this group had reported negative comments about their mother and half about their father. This ranged from aspects such as being caring, good listeners, non-judgmental, and accepting, to features about the parents, for example one participant described his parents as being very different to each other but close.

Um, it depends what I'm talking about I suppose. It's always clear that she has actually listened and, yeah. I guess it's like equals or whatever. You know, she's more talkative than Dad but they are both good listeners. (33, male)

They [parents] are very caring and very supportive of my sister and I and I think they would just about do anything for us. (66, female)

Well, strangely, it actually, I recall it as being relatively, relatively close and I mean, Mum, it's something like twenty-three or twenty-four years since Dad died and Mum's still very wistful and misses him so I mean, Dad was sort of wrong side of the tracks, the whole bit. They were very opposite in terms of background. Even personality, although they were both fundamentally caring, what you might call soft sort of pegboard. Other than that there wasn't a lot in common really. (24, male)

Over half of the group spoke positively at some stage about one or more siblings. For example, one had a brother who was supportive when the participant

was suicidal, two females were close to their sisters, and a male participant was protective of his sister while a female participant found her siblings to be protective. Three participants described a reasonable relationship with their siblings.

Oh, very close. Although we're different she's still, she's still, what's the word, fiery and likes to be the best but it doesn't worry me. We take each other for what we are. That's just totally different and she's really good, yeah. Grown up a lot, yeah. (67, female)

Um, easy, real easy. We spend lots of time together. Yeah, my brother's kind of an alien to me. I don't really know how he works but he's really warm, friendly and caring, just very different from me but still, it doesn't really matter. (33, male)

Of the participants who described positive relationships with their siblings, the majority had discussed some sort of negative aspect as well. However, similar to findings with mothers, almost half of those who described negative aspects of their siblings had not discussed positive aspects.

Participants in this study all reported positive and negative aspects of their upbringing which the researcher deemed as having possibly affected their attachment relationships. This could be the result of interviewing adults who were previously depressed and not currently depressed. The majority displayed a more positive view of life and their future which might have influenced how they viewed their history, allowing the happy memories to become more vivid. Had they been interviewed while depressed these happy memories might have been overlooked or dismissed. This was alluded to by Rikhye et al. (2008) when discussing whether depressive symptoms in their sample were the consequence of exposure to early life stress or the possibility of negative bias recall. However, Lizardi and Klein (2005) found, over a ninety-month period, that reporting on the PBI was relatively stable regardless of the fact that there were significant changes

in the levels of depressed mood in some patients. Livianos, Rojo, Rodrigo, and Cuquerella (1998) and Richter and Eismann (2001) had similar findings. Reporting quantitatively on psychological tests such as the PBI limits an individual's ability to explore in more depth their thoughts and feelings on such in-depth issues as attachment. Furthermore, previous attempts at interviewing currently depressed adults (Moyle, 2002) indicate that abilities to recollect memories are inhibited by an individual's current state of depression.

What was not measured in the above mentioned studies were chronological aspects of recollection. It has been found that older adults have a more favourable memory of how they were parented than younger adults (Anvin, 2004). Almost half of the participants in the current study were in the age bracket 36-45, with the next most common age bracket being 18-25, dispelling that theory.

Alternatively, a portion of the positive attachment reflected by this group (e.g. caring, good listeners, non-judgmental, accepting) could be the result of participants being 'dismissing adults'. According to attachment theory, dismissing adults are inclined not to talk about their parents or, alternatively put them on a pedestal (Riggs & Jacobvitz, 2002). All of the participants talked openly about their parents, the style of parenting, and for some how they perceived to have been affected by it as an adult. However, it could be argued that some of these participants had an idealized view of their parents. This was evidenced in a number of ways. One participant's parents could do little wrong at the start of the interview but wavered throughout the remainder between reporting what they did wrong (in particular his mother, e.g. being protective in a positive way at the start of the interview and manipulative and controlling later on) and justifying their actions with less justification for his mother. Another male participant often justified his father's actions while yet another spoke initially of his father as being "a bit brusque" (33, male) but considered him to be even tempered later on. One female participant also appeared to have a tendency to idealise her parents.

Clearly evidenced in this study was the inclination for participants to justify their father's negative actions and for those who reported negative aspects about their father to have reported positive attributes as well. This was not the same

regarding mothers, with only half of those who reported negative aspects reporting positive attributes.

A further consideration for positive reporting in interviews is the tendency for individuals to have a positive response bias when an interviewer is present (Feviele, Olsen, & Hogh, 2007). Feviele et al. (2007) compared mailed questionnaires to telephone interviews and found that the response patterns were significantly different between the two modes for health self assessment items. More positive responses were noted among respondents interviewed by telephone.

Summary

Behaviours which might result in negative attachment between the participant and one or both parents were discussed by all participants. Common problematic behaviours reported included poor communication or acting distant or remote, conflict in relationships, being overprotected, and dependency.

Poor communication was sometimes discussed as central to the participant and other times as being a problem with the parent. More often than not it was discussed in terms of being distant or remote rather than poor communication per se. Poor communication by fathers was more accepted than poor communication by mothers. Future assessment and communication could focus on communication styles in families and the psychological outfall, as well as cultural expectations.

Conflicted relationships varied between parents with fathers more likely to be described as being grumpy or fiery, and mothers as being hard on the children, judgmental, manipulative or biased. Almost half of this group described a tense atmosphere in the home when they were young.

Not quite half of the participants described overprotective parents with some of them acknowledging the long term consequences of this. Many of the bullied participants had parents who were overprotective. Dependency was problematic for a comparable number of the participants but not all the same participants who were overprotected.

The majority of the participants had one or both parents and/or siblings with psychiatric illnesses or alcohol addictions. Over half described their mother as having a mental illness and less than half their father. More prevalent amongst mothers than fathers was the suggestion of anxiety-related illnesses. Two participants discussed both parents as having a psychiatric illness and a small number had siblings with problems, mostly diagnosed with depression.

About half of this group perceived some form of abuse, mostly from parents. Only one participant discussed having been sexually abused which was by a sibling's friend (12, male). Non-parental abuse included verbal abuse by a relative (18, male), getting "hidings" from teachers and caregivers (6, male), being "put down" by an ex husband (67, female), and emotional abuse from an ex girlfriend (6, male).

Almost half of the participants perceived their parents to be abusive to some degree, the majority reporting emotional abuse. Emotional abuse was described predominantly as being controlled, but included being put down, manipulated, and being set up to fail. Some of the participants acknowledged the negative effect it had on them as they moved toward adulthood.

The majority of the participants discussed problematic relationships with their siblings. Many talked of conflict between them and their siblings, commonly being difficult or volatile. Half discussed negative perceptions of their siblings, for example calling them selfish, jealous, manipulative, spoiled, controlling, and overprotected. Of those who described negative perceptions of their siblings, all with the exception of one had described emotionally abusive behaviour from their parents.

All of the participants had positive expressions about one or both parents such as being encouraging and supportive. Most of the group of participants who described negative aspects about their father had described positive ones as well. Similarly, most of the participants who had described positive aspects about their mother had negative aspects as well. However, of the participants who described negative aspects of their mother only half had described positive aspects as well. Of those who spoke of their parents together in a positive light, the majority had

reported negative aspects regarding their mother and half regarding their father. Half of the participants felt that their relationship with their father had improved as an adult compared to two saying this about their relationship with their mother.

More than half of the participants reported positive feelings towards their siblings. These included being protective, being close, being supportive, and some described their relationship as “ok”. Of the participants who discussed positive aspects of their siblings, the majority had discussed negative aspects as well. However, almost half of those participants who discussed negative aspects of their siblings did not describe positive aspects.

Chapter 10

Maintaining/Unhelpful Factors

Woven throughout participants' stories were behaviours and patterns of thinking which were likely to have perpetuated the depressive symptoms, thus forming the Maintaining/Unhelpful Factors theme. Some patterns were recognised by the participants as being unhelpful and causing or maintaining their depressive state. Others were recognised by the researcher as common factors and likely to be causing problems. It will be acknowledged throughout this chapter whether or not the participant recognised their behaviour as being directly related to their depression.

In order to discuss this theme in a structured manner, it has been reported within four sub-themes, namely *Poor Coping*, *Interpersonal/Social Difficulties*, *Negative Perceptions of Self and Others*, and what the participants perceived as being *Unhelpful*.

Poor Coping

The development of poor coping skills is a common consequence of poor parental/infant attachment, resulting in individuals being susceptible to stress and depression (Kraaij et al., 2003; Matheson et al., 2005).

The inability of participants to cope with life stressors was evident throughout, whether explicitly articulated or implied by their behaviour. Three participants considered not coping to be the cause of their depression:

I just put it down to being so stressed out, not coping. Yeah. It's many factors but putting your finger on it, I don't know. (12, male)

...looking back at it, I've shut down and that's where it started. Anything that I couldn't handle I would just shut down, withdraw and ignore... (56, female)

Um, I don't know. I didn't cope with the workload and that's probably because I don't like internal assessments but I don't like exams either. I just didn't like the subjects I was doing and I, by the end of the year [6th form] I was on anti-depressants for the first time which was a rather scary experience I have to say. (66, female)

Whilst the majority of the participants did not overtly acknowledge that the coping strategies they employed were not helpful, the following two participants voiced the problematic nature of their chosen approach.

She's put up with a lot too and I'd never, ever, dispute that with anyone. She has put up with a lot. She has put up with a lot from me because I have, at times, been a real, can I say, bastard to live with you know, not violent but it's what comes out of the mouth when the kids, they get me so stressed out. I know that ... (12, male)

I just do it the worst way possible. Bottle everything up inside which isn't the best way. (18, male)

Avoidance

The most common unhelpful coping strategy used by this group was avoidance, whether it was bottling things up as with the above participant, direct avoidance, or procrastination, with 11 of the 13 participants having actively avoided perceived stressful situations at some stage.

The following participants also used 'bottling', keeping a stressor to themselves, in their attempt to cope. As with the above participant, the first two bottled and internalized their stress, often for years. The next two recognised that their stress did not diminish but built up until their emotions could no longer be contained. At that point, they were in an increased stressed condition when they attempted to problem solve and therefore had a tendency to "blow up" (82, female).

I think being able to talk about it. You know, the idea, because I don't you see, I keep it to myself... (1, male)

I bottled that up [sexual abuse] for years and only came out with it and spoke to [wife] about it ... (12, male)

Yeah, sometimes. Sometimes just keep it to myself. Until it starts building up and then you need to do something about it. (21, male)

[Sister] and I always shared a room and both of us are, well, she's fairly volatile and I can be volatile when pushed, you know. If I hold on to things long enough I'm going to blow up so we had a very stormy relationship. (82, female)

Underdeveloped problem solving skills in these participants made it difficult for them to successfully work through stressful situations. Thus the choice was often to avoid circumstances that were perceived as distressing. For some, it was only in more recent times that they spoke of long-standing troubles as with participants 1 and 12 (males) above. Having spoken about it to someone appears to have been the start of healing for these participants. On the other hand, participants 21 (male) and 82 (female) simply appear to be more reflective of a coping style that they have become aware of.

Over half of the participants directly avoided stress inducing situations, highlighting their lack of helpful coping skills. On reflection, some described 'shutting down' and completely ignoring stressful situations, perpetuating rather than alleviating their problems, for example:

...looking back at it, I've shut down and that's where it started. Anything that I couldn't handle I would just shut down, withdraw and ignore it... (56, female)

Basically just watched TV and let the world go by and just didn't really do anything. I just sort of closed down my brain. Just sort of, umm. (18, male)

Other participants avoided stressful situations by removing themselves and using distraction through other activities such as going to the library or concentrating on current family activities as with these examples:

INT: *So was finding the library a good thing because you got to read a lot or a good thing because you got to get away from the bullies?*

Good thing because I got away from the bullies because they wouldn't go in there because it's not a cool place to go. You can quite successfully hide in the library and I like books. (66, female)

I had some awful nicknames in that patch of time as well and the only solace I got was from being in the library and being a librarian because they were the only group of people that were nice to me (laughs). (69, female)

There is one other thing I have left out of there, too. It's about round about the age of ten I was sexually abused and I'm going to go for counselling but I have had so much on my plate with [son], although [son]'s just started a course today, yesterday at the forestry, it's fantastic, he got in just like that and he's loving it. (12, male)

Putting things off or deferring action until a later time, procrastination, is another form of avoidance which a few of these participants related to. Procrastination for one participant was considered to be directly correlated to his depression.

This might sound completely stupid but if I had to, the correlation between depression and me is associated with procrastination. My depression is

directly linked, I believe, to the fact that I can't study, you know, and whilst I can't, it seems to be more I won't. (1, male)

The following two participants recognised that they had deferred action without specifically discussing it in terms of relating it to their depressive symptoms. In fact, participant 18 (male) did not discuss causes of his depression in his interview. However, from the researcher's perspective, this type of avoidance may induce stress at some level.

I should have really done that months ago but I have been holding it off and holding it off because I would rather, if I started a business or got a job. (18, male)

I need to finish the qualification that I started. All it is is half an hour's worth of paperwork that I need to sit down and complete and I've finished the adult literacy qualification so it doesn't take long at all. I think I'm such a procrastinator but I need to do that. (69, female)

It would seem that avoidant coping is a more elaborate phenomenon than previous research has implied. Each different type of avoidant coping likely produces differing results in terms of depressive symptoms and other psychological problems.

It might be culturally related as implied by Mosher and Prelow (2007) and Zhang et al. (2009). Perhaps each culture has learned a different type of avoidant coping which, in turn, produces differing levels of depressive symptoms. Should it be culturally bound, then avoidant coping in the New Zealand context would concur with research (Kort-Butler, 2009; Lewis & Frydenberg, 2004; Nagase et al., 2009) that concludes that avoidant coping correlates with depression.

Research conducted with older adults in New Zealand confirmed correlations between what the researchers termed experiential avoidance and both depression and anxiety (Andrew & Dulin, 2007). Experiential avoidance was

described similarly to avoidant coping. Regression analyses confirmed a much larger predictive contribution to anxiety than depression (11% and 4% respectively). A more recent study produced similar results indicating that avoidant coping was related to anxiety (Vierhaus & Lohaus, 2009). These findings fit with previous research which associates avoidance with the maintenance of anxiety (Freeman et al., 2004; Ladouceur et al., 2000). Furthermore, according to the DSM-IV-TR, avoidance is associated with Social Phobia (APA, 2000), an anxiety-related disorder. Certainly, it was clear from my research that anxiety was present amongst all participants.

Furthermore, the majority of participants were bullied at school, many of them using avoidant coping techniques. This concurs with research conducted in Australia with adolescents which indicated that appearance-related victimization problems correlated with avoidant coping and lower self-esteem (Lodge & Feldman, 2007). Additionally, as with my research, Lodge and Feldman (2007), and Seiffge-Krenke and Klessinger (2000) found no gender differences.

Highlighted is the need for further research on avoidant coping. More specifically, each type of avoidant coping and its effects on psychological well-being.

Indicated by the present study and previous research is that teaching coping skills and their respective consequences would be useful. More specifically, it has been suggested that teaching the detrimental effects of avoidant coping and how to reduce avoidant coping strategies might be more beneficial than focusing primarily on promoting problem-focused coping (Lewis & Frydenberg, 2004). This might be most useful taught in a school-based programme as suggested by Lodge and Feldman (2007).

Alcohol

A coping strategy used by four of the participants (3 males, 1 female) was the consumption of alcohol. Two of the participants discussed their drinking in terms of whether or not they were currently drinking (one used to drink and was not at the time of the interview and the other had 'been dry' (1, male) until the year his

mother died but had been drinking again at the time of the interview). Neither discussed their drinking in association with their depression.

However, the following two participants recognised that their alcohol use might have been related to their mood and was likely to be a form of self-medication.

INT: *Do you mean from one time to the next as opposed to monthly [positive or negative change while filling out questionnaires]?*

Ah, yeah, slowly, slowly went down hill and it occurred to me, I said to X that it occurred to me that whether it was cause or effect, I don't know, but that was sort of paralleled by increased drinking. I don't know whether that was driving my mood down or some sort of self-medication type approach. (33, male)

My doctor knew that I always had an issue with how much I was drinking and it was a, it was, it was basically a self medication mission and I didn't realise how much it was affecting my life until I got into the study and started noticing, because I started to feel better taking the thing, and then I would go and drink a couple of bottles of wine and there would be the conflict in the body. The body wanting to rev up and the alcohol wanting to slow it down and making you groggy and feeling awful so actually during the study, I actually talked to our EAP counsellor at work about that so, although I have not sought formal counselling for it, I've actually changed that behaviour big time, yeah. (82, female)

The first participant, 33 (male), was unaware of the exact connection between his drinking and how it affected his mood. However, he became aware of an association during the course of the DIS, in particular through filling out the required questionnaires for that study. On the other hand, participant 82 (female) described an awareness being associated with how her body felt during that time and making changes accordingly.

Disorders of alcohol use and depression have been found to be correlated (Meririnne et al., 2010; Ogasawara et al., 2011) and are commonly co-morbid (Sadock & Sadock, 2007). Both of the above participants perceived their alcohol consumption to be a form of self-medication, indicating that psychological distress came before excessive alcohol consumption. Other recent research concurs with these findings. Caselli et al. (2010) concluded that rumination predicted levels of alcohol consumption in out-patient alcohol abusers at follow-up intervals of 3-, 6-, and 12-months. This was independent of initial level of alcohol use and depression.

Conversely, Skogen, Harvey, Henderson, Stordal, and Mykletun (2009) found that abstention and low levels of alcohol intake increased the risk of depression and anxiety compared to moderate levels of alcohol consumption.

It would seem that there is a possible connection between alcohol consumption and depression. With three men and one woman discussing the use of alcohol, a small gender difference was apparent although there were more men than women in this study. Wilhelm et al. (2008) also found that men with depression were more inclined than women to engage in substance use. Recent research has found, when comparing interventions, that alcohol-focused intervention was more helpful than depression-focused in reducing men's alcohol consumption and improving their functioning (Baker et al., 2010). For women, the opposite was found. That is, that depression-focused intervention reduced depressive symptoms and reduced consumption of alcohol. Further research is required to confirm and extend these initial findings.

Breakdown

Another indication of life stress, and perhaps of poor ability to cope with stress, is whether a person has experienced a 'breakdown'. Two male participants had experienced what they described as a breakdown. For example:

Hard question to recall but I remember breaking down and ringing the Managing Director of the company in Auckland and saying that I had had it.

Couldn't go any further and he could stick his job up his bum to put it politely. Their reaction was one; their immediate reaction was one of concern. "[participant], don't do anything rash. Go home. Take it easy. Have a week off." I think I did that from memory. Went back and surprise, surprise, in ten days I essentially did the same thing again. I think this time I stormed into the bosses office, locally, the branch manager and told him what I thought of him, threw the car keys on his desk and walked home which was about a one hour walk, six or seven kilometres. (24, male)

Although not specifically discussed, it would seem likely that stress had been building for this participant cumulatively. Thus, one week off work with no changes to work stressors on return was unlikely to lessen his stress levels.

Breakdowns, nervous breakdowns, or mental breakdowns are all common terms for this phenomenon with scattered research. A recent study found similar results to mine. Bryant-Bedell and Waite (2010) found that stressful life events led African American men to experience depression which was then followed by a breakdown. They described the consequential breakdown as being the result of limited coping skills to resolve the depression.

As with participant 24 (male) above, other research has associated breakdowns with excessive stress in the work place (Hodgkinson, 2007; Miner, 2010).

Interestingly, it was men in the current and two other studies (Bryant-Bedell & Waite, 2010; Hodgkinson, 2007) who had been described as having breakdowns. This study had a higher ratio of men and Bryant-Bedell and Waite's and Hodgkinson's studies included men only. However, when my participants were asked about parental mental illness, four discussed their mothers as having had breakdowns. No fathers in this study had experienced the phenomenon. Should breakdowns be the consequence of depression, it would be expected that more women than men would experience them as twice as many women are reported to experience depression (Sadock & Sadock, 2007). Could it be that women experience symptoms akin to a breakdown but manage to hide many of

the serious consequences when not in the work force? For example, a married woman at home with children might manage to get out of bed long enough to get children off to school, go back to bed for the day, and get up in time to pick children up after school. Her husband might ‘give her a break’ when he gets home from work and take care of the children for the evening.

The current research has uncovered more questions than answers with regard to breakdowns. This opens up opportunities for future research to focus beyond consequences that cannot be covered up, such as not being able to continue with employment.

Suicidal Ideation or Attempts

Similarly, suicidal ideation or past suicide attempts generally indicate that a person is not coping with life stress and it has been found to be associated with depression (Beautrais, Wells, McGee, & Oakley-Browne, 2006; Josephson, 2007; MacDonald, Taylor, & Clarke, 2009).

Half of this group had either attempted suicide or had thought about it (5 males, 1 female). For these people, there appeared to be no other option at the time of their distress.

It's many factors but putting your finger on it, I don't know. But there is depression there. I mean I have tried to top myself more than once. The odd thing about that is I'm scared of death. I am scared of death but I think you get to a stage in life where you just, you know. (12, male)

I had been brought up to revere books and magazines and still do and that was a shocking thing when they did that so I went up to my room and tried to commit suicide. I took the plug off the wall and got a hell of a shock when I touched the two and got blown back a bit because the thing went bang and turned black.

INT: *Was that a real attempt?*

Yeah, yeah, yeah it was. I mean I had taken the thing off and I knew that inside the wall that there was three. If you touched the right two you get fried and, well I did touch two and there was a bang and I did get knocked backwards so I got a bit of a shock from that. They were outside burning the books and my brother was happily helping them and so there was and everyone was there so while they were out the back I came downstairs, went out the front door and ran away.

INT: *So how old were you then?*

Fourteen. Yeah, I was in the sixth form. (1, male)

The first participant, 12 (male), related his suicide attempt to depression and, regardless of his fear of death, at times was unable to cope with his emotions. On the other hand, participant 1 (male) related his suicide attempt to a specific stressor for which further details of his emotions were not elicited.

In contrast to findings by Beauvais et al. (2006) and Ehnvall et al. (2008), the majority of these participants were male.

Concurring with Coggan et al. (2003), Maxwell and Carroll-Lind (1997), Rigby (2001), and Schuster (2001), with the exception of two participants, those who attempted suicide or reported suicidal ideation had been bullied at school. The present results indicate a more probable association between suicide and being bullied rather than it being related to gender.

Interpersonal/Social Difficulties

Impacting on a person's ability to cope is their ability to communicate and interact in family and social settings. All 13 participants were identified by the researcher as having had interpersonal and/or social concerns to varying degrees. Some of the difficulties were identified as being behaviour pertinent to the participant, for example fighting as a teenager. Other difficulties were linked to other people in their lives such as having a parent or parents who were non-communicative.

Communication

Following findings and discussion regarding poor communication in the theme Negative Attachment Styles, it would be expected that communication for these participants would be problematic in later life.

Communication was identified overwhelmingly as problematic on some level with all participants. As discussed seven of the participants discussed having poor communication with one or both parents. All of the participants who discussed limited communication with their parents went on to have communication difficulties themselves, whether spoken about explicitly as with this participant:

People say I sound grumpy on the phone when I'm talking.... to a party or a function but I stand back. I sort of don't make conversation easily but no... (12, male)

Or implicitly, for example, rather than acknowledging poor communication per se the following participants recognised that they had difficulty getting on with people. The first two examples were shown through internalizing behaviour, the most common being shyness and lacking in confidence, and the last example is of externalized behaviour. Other examples of external behaviour indicating interpersonal problems were fighting, being tough and bullying.

I didn't feel like I fitted in really. I was pretty shy and really, I don't know, maybe I hadn't really worked out how to get on with people. I always had one friend pretty much, that was always enough. I tend to have one best friend. I didn't, I guess I didn't enjoy most of the stuff we had to do at school. I hated team sports... (33, male)

Just that I didn't mix with other people very well and not having enough personal confidence in myself... (56, female)

It [medication] was after I left school and had done a polytech course up north in Kerikeri and got kicked off that course because I was being disruptive and yeah, it was after that. (18, male)

As discussed in *Stress in School and Bullying*, explanations could be bullying by exclusion or relational bullying (Crick & Grotpeter, 1995), or social anxiety (Ranta et al., 2009), and lack of self-confidence as indicated by participant 56 (female).

Furthermore, Feely et al. (2007) found that shyness was often fuelled by fear of common social situations such as asking a girl to dance. Participants in the current study who referred to shyness also referred to being scared in social situations, indicating an association. Shyness is a common trait of social phobia (Sadock & Sadock, 2007). In addition, parents of shy children are often rejecting, less caring, and overprotective. Overprotective parenting was discussed in Chapter 8 as being common among the participants who had been bullied at school, and in Chapter 9, *Negative Attachment Styles*.

Loneliness

Identified was an association between poor communication and loneliness. Out of the seven participants who talked about being lonely, five of them had been identified as being ineffective communicators. For some of the participants loneliness began at school age. For others it was after moving away from familiar surroundings and family support as previously discussed.

...perhaps move in some ways and I always wanted to go to Australia and the boyfriend said that he was going over to New Zealand so I went with him.

INT: *How did you find it when you came here?*

Very lonely. (67, female)

As well as communication, this group identified loneliness as being the result of problematic relationships and relocating discussed in the theme Stress and Anxiety – Causes and Consequences.

With the exception of one participant, the participants who described being lonely also reported being bullied at school. In addition, half of the participants describing loneliness described one or both parents as being overprotective.

Overprotection by parents has been associated with loneliness in offspring in previous research, particularly in girls (Richaud de Minzi, 2006). Reasons were described as fostering social isolation (Richaud de Minzi, 1999) and resentment which can affect a child's general ability to approach others (Richaud de Minzi, 2006). No gender differences were apparent in the current research.

In their qualitative exploration, Feely et al. (2007) also found loneliness to be part of the depression experience. Their participants associated loneliness most often with shyness and bottling negative experiences which many of these participants did.

Certainly, this research brings together stress, loneliness, poor communication, dysfunctional relationships, being bullied, being overprotected, and being anxious, including social anxiety.

Negative Perceptions of Self and Others

Widespread amongst this group of participants was their tendency to view themselves, others, or the world around them in a negative manner. This was evidenced in the way they spoke about themselves portraying feelings of worthlessness or being disappointed in themselves, and how they spoke of others, for instance feelings of bitterness or blaming towards others. Some identified with an emotion and recognised it as being problematic while others discussed observations which the researcher identified as likely to be problematic.

Self-Criticism

The majority of the participants had feelings of self doubt, inadequacy, and/or a fear of failure, with a few having a complete belief in being a failure, leaving them with feelings of insecurity, shyness, and in need of reassurance. Self-criticism is a personality trait found to be associated with depression (Campos, Besser, & Blatt, 2010; Luyten et al., 2007). Luyten et al. (2007) found that women with psychiatric disorders including depression had higher levels of self-criticism than men. No such gender differences were apparent in this study.

Furthermore, self-criticism was found to impede treatment of depression in a study using interpersonal therapy (Marshall et al., 2008). They found that individuals with high self-criticism responded better to pharmacotherapy with clinical management. Further research regarding the effects of self-criticism, and how best to change the behaviour, is imperative for the further development of successful treatment plans for depression.

The following examples show the troublesome feelings of self doubt common amongst this group and the variety of ways they were illustrated:

...I was insecure about moving out because I thought the moment I move out they are going to say "Oh, this flat's no good. You can't handle this. You had better go home." You know. I just could not handle that. (6, male)
(Insecure)

...because of our early training we didn't have any assertiveness about us anyway. We weren't assertive kids and I mean, any of the assertiveness that we may have had growing up had probably been choked out of us when we were young anyway. (11, male) (Lacked assertiveness)

Yes but because he is quiet [son] he doesn't come out and say well "Gee, you were brilliant today. You're a real help to me." So once again it's having to do the work for myself and to say that okay, I didn't succeed in an interview, I didn't get another job but realising now that maybe I couldn't

cope. I knew I couldn't cope with a full time job but just appreciating that I am valuable. (56, female) (Needs reassurance)

Yeah. [Wife]'s very strong. In fact she's stronger than what I am and like, see ours, see if [wife] wasn't there, I would be completely stuffed because she handles all the money side of things because she's better with money than what I am. People say I sound grumpy on the phone when I'm talking. It doesn't matter whether I'm having a good day or a bad day they say I'm very abrupt. I don't know I'm being abrupt. [Wife] has a far better telephone manner than what I do talking to people but I can go into a group, into anywhere, to a party or a function but I stand back. I sort of don't make conversation easily but no, [wife], [wife]'s the backbone. (12, male) (Comparing to others)

Participants 6 and 11 (males) above related their feelings to how they were brought up. One was insecure and related this to past parental behaviours. The other lacked assertiveness and connected this to his upbringing. However, participants 56 (female) and 12 (male) discussed no such connections. Participant 12 (male) compared his perceived wife's abilities against his own apparent lack of abilities and accepted that she was the backbone to their relationship. In the PHQ-F he stated that his first depression was in the last five or six years caused by being stressed out and not coping. Participant 56 (female) did not discuss a known need for reassurance. These words are the researcher's. There appeared to be a desire on her part for her son to acknowledge that she was doing a good job and, according to her PHQ-F, her first depression was after she had her children and continued into the break up of her marriage.

Insecurity, as discussed in the sub-theme Anxiety, was associated with higher levels of self-reported psychopathology for individuals who were experiencing high levels of life stressors (Fortuna & Roisman, 2008). For some, the feelings were more intense and longstanding, appearing as a core belief of being a failure. For example:

Um, it took me a long time to come to terms with it. There were issues of “Shit, I’m a failure” was, that was right up there! Um and I didn’t tell my family. Mental illness, with Mum having gone through what she had gone through I felt it was a very much taboo subject. Um, ah, yeah, yeah, there were a lot of issues around ‘shit you’re a failure’, you know. Why can’t you just totally get on with your life! You know? Other people do it, other people cope with it, you know, pull your head out and get on with it. (82, female)

Trying to stop the negative tapes in my head. I find that is very, the hardest thing to do because I sort of look on myself as a failure and don’t, I can’t really see my strong points... (56, female)

Similar to feelings of failure are feelings of worthlessness and general negative thinking which, again, the majority of this group were implicated. Such feelings are common in depressed individuals (Cheng-Sheng, Mian-Yoon, & Hin-Yeung, 2007; Rohde, Beevers, Stice, & O’Neil, 2009; Sadock & Sadock, 2007). Feelings of worthlessness are included in the DSM-IV-TR as criteria for Major Depressive Disorder (APA, 2000).

Self-Pressure

For just under half of this group, there was a common thread pertaining to pressure on the self. This was in a variety of forms from over-analysis, having high expectations of the self, needing to be liked, being taught to please others, and putting up with things without attempting to change even when it was detrimental to the participant, for example:

Have always done I think. I think, not a fault that I could attach to myself, I think I have got an unhealthily large desire to be liked and so the relaxed and amenable nature, I’m not consciously doing it now but it’s probably

become such a habit and I expect it's all tied into that unhealthy large desire to be liked. (24, male)

One of the things I remember my father saying to me when I was a kid, and he was dead right, he said "Your problem is that you do things to excess" like if you are going to do something, you will do it way over here and the same thing applies on this side. If I'm not going to do something, it won't be half though; it will be bugger all done. (1, male)

If we hadn't have moved from our own home I probably would have just continued to put up with it. (56, female)

Participant 24 (male) appeared to be ambivalent, likely making it difficult for him to describe how he felt as his feelings were likely mixed. On the one hand he began by considering it "not a fault". However, he went on to mention more than once his "unhealthy large desire to be liked". Self-criticism and self-pressure are similar constructs. The need to be liked was apparent in Feely et al.'s (2007) study which outlined the detrimental effects it had on mental health. Similarly, participant 1 (male) swung between doing things to excess and not doing things at all. Again, he did not discuss in more detail how this affected him beyond his tendency to procrastinate which he attributed to being where his depression stemmed from.

Negative Thinking

The following are examples of negative thinking and the variety of ways it was demonstrated.

Oh again, I had no confidence in myself. I felt, I never really knew what true love was because I had never ever really been given true love. A child will give love, you know, even a young child will come along and give you a cuddle but it's not really true love. And I felt that I didn't have any of that.

I had no one really to, you know, friends of mine were getting married, friends of mine were having kids. Friends of mine were going overseas you know and I never really had that confidence or that love of anybody and of course, I used to do, my father never agreed with it but I got my gun licence. I used to do a lot of shooting to take my mind off these things and yeah and I felt that I just really wasn't a good person. I felt that I was really not a person for society. (6, male) (Felt not good enough)

I really need to sort of work deeper at changing the negative and changing my responses. (56, female) (Recognised negative talk)

INT: *What about the most significant positive things that might have happened to you?'*

(Pauses) Can't think of any.

INT: *You mentioned your wife. Is it X?*

Oh yeah, that's definitely a positive one, meeting her. Um, doing the polytech course... (18, male) (Slow to recognise positive life events)

The first example is more a reflection of how participant 6 (male) felt when he was younger. He began by considering that he lacked confidence followed by a discussion of true love and his perceived lack of this which culminated in him feeling that he was a person not fit for society. The second participant, 56 (female), described her thinking style as negative with a desire to make changes. The last participant, 18 (male), was not discussing negative thinking per se. His lack of ability to think of positive life events before being prompted could indicate a negative thinking style. However, this is not necessarily linked to a depressive style of thinking as he considered that depression bothered him considerably less at the time of interview as compared to when he began the DIS (Time 1 – 7; Time 2 – 3).

For a few participants the negative thoughts and feelings about themselves had been with them for many years, eventuating in a core belief of being worthless or useless.

... Dad thought it would be better if I left school so I was at home and after being, like made to feel really like worthless, I was at home just with those thoughts going round and round in my head and ... (18, male)

I've always gone through life thinking I'm useless and yeah, yeah. I know I'm not useless. (12, male)

Like for me, it's just a feeling of not being able to do anything, of being able to cope and that's quite hard, feeling like you are kind of useless... (66, female)

As discussed in the theme Stress and Anxiety – Causes and Consequences, Feely et al. (2007) found that individuals who experienced negative early life experiences felt that they shaped their sense of self-worth which stayed with them into adulthood. Certainly, the majority of the current participants had experienced more than one childhood negative life experience which appears to have helped shape their perception of who they are as an adult. Contrary to research by Sigfusdottir and Silver (2009) who found clear gender differences regarding negative life events, there were few clear gender differences in this study.

What is clear from the present study is that self-defeating patterns for this group of participants appear to maintain dysfunctional states and result in continued negative psychological consequences. Wei and Ku (2007) reported similar findings stating that “adult attachment (i.e. anxiety and avoidance) is related to distress (i.e. depression and interpersonal distress) through self-defeating patterns” (p.301). Results reported thus far in the current study indicate that self-defeating patterns for these participants appeared to begin at a young age

in the home with their primary attachment figures and continued into adulthood as no improved style of coping had been learned during the developmental course.

Resentment towards Others

Included in this sub theme are common negative feelings held towards other people such as resentment, blaming, bitterness, envy and jealousy which can contribute to an individual's negative cycle.

Nine participants talked about some form of resentful feelings towards others with resentment and blaming being the most common. Resentment was evident in the following discussions. The first discusses resentment felt by the participant as well as reciprocated resentment by his brother, and the second is resentment not uncommonly felt initially towards a younger sibling but has continued into adulthood.

He was very materialistic where the rest of us weren't and yeah, there's a bit of resentment on my part there. I don't sort of, I looked after him but, you know, as soon as I left home, I walked out the first time, I actually basically ran away again and this time I didn't go home, he went into my room and took my card albums I was very proud of and cut them out and wrecked them basically. Also I do believe there might have been a bit of resentment on his part because I was the oldest and I was promoted at school and sort of singled out as, you know, being not quite average and I really do believe that there was some resentment. For example, you know, all my table tennis certificates are missing. Yeah, he's got an album there, when he got married the first time, I saw his album and he's got a picture of himself in front of all the cups which two are his and the rest are mine but he's got 'cups I won playing table tennis' (1, male)

...but my sister's two years but she was more the baby always. We always did what she wanted and she had to win and all that.

INT: *Okay. So what was that like for you when you were young? How did you find that?*

I felt it mad for my Mum because like, she always had to have a nice dress because we had to keep her happy and I always had to wear the blue you know, and I didn't mind at the time but, I didn't say anything but [sister] always had to be the best and the prettiest otherwise she would have a ... (67, female)

Five of the participants had a tendency to blame others for their problems as with the following examples.

I blame that on the fact that we don't have a close relationship [daughter born in Rotorua during bad time] because I was so busy trying to come to grips with this terrible person to work for and trying to keep a family together and keep myself upright. (11, male)

...before I fell over I was actually with them for a period of fourteen years but I'm convinced in my own mind, I mean, shortly after I fell over I thought they were ninety percent responsible for my demise. Now I've moderated a little bit and only give them fifty percent of the responsibility but really, my [company]'s boss was absolutely right. I should have stuck to the devil I know because I was fundamentally incompatible with this new employer. (24, male)

Resentment and bitterness as specific constructs draw limited research. However, previous research has found that resentment and depression were associated (Jackson, 1999), as were bitterness and depression (Maisel, 2003).

More than half of the participants had unfavourable perceptions of others with the majority pertaining to a family member and a small number relating to people outside the family such as a general lack of respect for others (33, male)

and teachers ignoring the participant (18, male). The most common negative perception of others involved a sibling, for example:

She was spoilt. She got her own way all the way through. Mum, I think, spoilt her. She was over protected as a child. She has no comprehension what the real world's like and I still take care of the real problems actually, you know, so, she's never really, till Mum died, really had to fend for herself at all. (1, male)

...my sister was being favoured. Whether that was right or wrong I don't know why but that's how it seemed to me at the time. She was being allowed to do things that I weren't allowed to do. (11, male)

The above findings of unfavourable perceptions could be considered negative perceptions. It is well known from previous research that depressed individuals perceive themselves and the world around them as negative (Feixas, Erazo-Caicedo, Harter, & Bach, 2008). Furthermore, they perceive themselves as 'different' from others, a feeling which many participants in the current research share. However, participant 11 (male), in particular, considered himself considerably less bothered by depression at the time of interview compared to when he began the DIS (Time 1 – 9; Time 2 – 3).

Not Helpful

This sub-theme allowed a frank description of what the participants highlighted as having been unhelpful. These vary and include areas such as talking therapies and medication, as well as practical factors, for instance, advice, and how lack of sleep was not helpful. Additionally, it includes topics that, from the researcher's perspective might also have been unhelpful and which have not been discussed within other themes, for example, lack of understanding by the participants.

Helping Professions

More than three quarters of the participants, 7 males and 3 females, found aspects of the helping professions unhelpful. Half found the talking therapies' professions to be unhelpful. One found psychologists to be unhelpful, another assertiveness training, and one found anger management did not give him understanding. The other three had various forms of counselling which they found unhelpful.

... I have done umpteen dozen assertive training courses and none of them worked. (11, male)

Oh I think it was, it was a bit like when I talked to you on the phone the other day, the verbalising it. Made it harder to ignore, how crap I was feeling, how out of control and stuff and I didn't, didn't manage to glean any hope or feelings of hope from the counsellor or yeah, or talking about it. I doggedly carried on going and certainly didn't really get anywhere. (33, male)

Yeah, how it had affected them and I could understand them saying that like once and how it affected them but they just kept doing it over and over again and "Why did you do this" and "This is what you have done to them." Make me feel worse and worse and worse. That happened for, oh, weeks! They got me to continually go back to the counsellor and the counsellor definitely wasn't helping me. The counsellor was probably helping other people to deal with it because they couldn't understand how I wasn't that happy at the time and getting my point of view and it was probably helping them but definitely wasn't helping me. (18, male)

the first time I tried to talk about that problem, I mean, the psychologist gave me a book to read and that was just, I mean you had to be frigging stupid to come up with that as a possible solution to someone who's saying "I don't study". That book caused me heaps of problems! (1, male)

Gleaned from this information is the importance of being aware of and understanding individual experiences. It is important to continually check with a client/patient what they hope to get out of therapy and reflect on whether that is being achieved to date with the current chosen model of therapy? Participant 11 (male) had attempted training courses in the past with no success. Therefore, putting him through another training course was likely to be unproductive. It had been made clear by participant 1 (male) that he was unlikely to read a book if suggested and that his level of procrastination would probably cause him ongoing problems with the book. Participant 33 (male) confirmed the importance of instilling hope into individuals presenting with a mental illness. Ridge and Ziebland (2006) also found that establishing hope with individuals was important. Again, it is important to revisit this throughout the sessions, not only at the point of assessment.

Additionally, clinicians need to reflect on the type of therapy used, including the decision to use group or individual therapy. Participant 11 (male) might be a candidate for individual therapy as several groups have not worked for him.

Medical Profession

More than half of the group found aspects of the medical profession to be unhelpful, mostly regarding medication. Some found medication not helpful, some noted good and bad aspects of it, and one talked about finding the doctor unhelpful because only medication was prescribed with no talking.

*I don't know. I mean, I used to think that maybe drugs would help you know and I wanted to try Prozac to see if it did and it didn't. Didn't help at all.
(1, male)*

I was on medication but it wasn't working that wonderful. I was still having periods where I just couldn't do anything. (18, male)

No. Only briefly. Sixteen days on Prozac. I can't recall the dose. It might have been sixty milligrams, I can't recall but I got a huge adrenalin release that stimulated the renal gland something wicked and I hated that so I went back to my GP and said "I can't cope with this adrenalin release. Any objection if I stop taking these things?" and no, he had no objection so fundamentally that was the end of the treatment. (24, male)

He did that and I think I must have scored enough that he decided I needed anti-depressants so he gave me some pills and sent me home to which I don't think was a wise move for a seventeen year old. I mean, I could have just taken the whole packet and killed myself because that was how I was feeling. So I don't actually think he helped me at all. (66, female)

As discussed in the introduction, a GP's first line of treatment for depression is anti-depressants (Kotz, 2007; Sundhedsstyrelsen, 2007, as cited in Hougaard, 2010). However, it would seem that anti-depressants are not considered helpful or appropriate by some consumers. According to Malpass et al. (2009), whose research was designed to assess why consumers do not complete anti-depressant treatment in a bid to enhance their use, GPs could increase use by involving patients in shared decision-making and discussing with patients individual experiences which might inhibit use. The current participants report mixed results but lean towards anti-depressants being an ineffective treatment for them, disregarding GP discussion. Further research into consumers' perspectives of their use of antidepressants is required to help GPs and other health professionals who prescribe them enhance their understanding of what taking them might mean to their patients.

Although the current participants also had positive things to say about the helping professions as discussed in the following chapter, results of a study in Germany also indicated a general dissatisfaction in health professionals' treatment of depression (Angermeyer, Mataschinger, & Riedel-Heller, 1999). General

public opinion in Germany was that schizophrenia was successfully treated by health professionals but depression was not. Their view was that depression was best treated within their own support system and the family GP was only resorted to once their support system was exhausted. As previously discussed, for many in this study the individual's support system had been removed or depleted. Implications lean towards helping rebuild a support system which would most benefit the individual. This might include improving relationships with family and friends, improving communication and coping skills designed to improve relationships, or helping to build a new network of support within their community as examples gleaned from findings in this and previous chapters.

Advice

A small number of participants found advice unhelpful. This was determined by asking the participants what advice they would give a friend with depression.

I don't think I would be giving them any advice except that just hang in there and talk to them. That's about it. I'm absolutely annoyed now, when I try to talk like I have raised it with my own doctor a few weeks ago, you know, about the problem and I got all the same, blimMING sanctimonious answers you can get and it just, it annoyed me that the doctor could think that I was that stupid and I needed that kind of advice so, you know... (1, male)

Oh, I have friends; I have two who are on anti depressants, two friends. I don't give them advice. I listen to them when they need to be listened to. One thing I've learned about talking to people, there's nothing worse than people trying to give you advice. Sometimes you just need someone to say, "Yeah, that sucks doesn't it?" instead of all the clichés and stuff like that. There's a time and place for clichés. I don't, I just listen. (69, female)

Not wanting advice is compatible with the premise of CBT. Although considered directive in its approach (Beutler et al., 2004), cognitive behaviour therapists are encouraged to use techniques such as Socratic questioning to guide their client towards a more helpful way of thinking rather than offering direct advice.

Stigma

Three female participants felt that the stigma attached to mental illness was bad and detrimental to individuals accessing professional help.

Um, take each day as it comes and don't dwell on it too much, that it is, it does affect a lot of people. It's not a bad thing. I mean, it affects something like one in five people and that's a lot of people and I don't like all this stigma that's attached to it. (66, female)

Probably I've had it on and off for about twenty-five years but because of the stigma of it and sort of had it thrown up as something bad at me as a child, I just refused to acknowledge it and it was never actually diagnosed until fairly recently. (56, female)

Um, to a degree. Looking back now I would have liked it if I had sought more talk therapy earlier on but I also felt there was a stigma to going to a psychologist. (82, female)

For this group, stigma meant a variety of things. The first participant perceives other people to attach a stigma to mental illness but it would seem she does not. The second participant perceived a stigma for herself and consequently delayed help-seeking. The last participant specified the stigma attached to seeing a psychologist. Certainly, the last two quotes indicate that the individuals have suffered a degree of mental illness for longer than perhaps was necessary because of the stigma they perceived.

Other research found similar results regarding the stigma surrounding mental illness. Koekkoek, Van Meijel, Schene, and Hutschemaekers (2008), through focus groups, found negative experiences for their participants included the negative connotations of chronic depression. This included health professionals as well as the lay public. A pessimistic attitude by some professionals was experienced indicating to the participants that some professionals did not take chronic depression seriously.

Attempts are being made at reducing the stigma of mental illness by way of normalising it through television advertising. Whilst this might be beneficial for some, one participant voiced his negative opinion.

I tell you what, those ads on television, I mean; people have told me that they quite like them. The mental health ads. They annoy the bloody crap out of me, excuse the language. (1, male)

Perhaps Restifo (2009) has a point; that the term depression has become too broad for clinical utility. He suggested that the stigma surrounding depression might be reduced if the terminology reflected more accurately individual experience. Examples he suggests pertinent to my participants include grief, loneliness, low mood, and having a negative sense of self.

Understanding

The researcher noted that a small number of male participants had limited understanding of addiction, mental illness or family dynamics, all of which might impact on their mental health. For example:

INT: *What sort of things make you anxious?*

That's a good question.

INT: *Do you have a good answer?*

I wish I did. I don't know. Just depends really. Depends what's going on, yeah. (21, male)

INT: *What do you think would be the first indicators for you if something was improving?*

The first indicator? I find that quite tricky because depression, alcoholism is so intertwined in the way that I experience it, I sort of tended to say the first thing would be drinking less or feeling less compelled to drink but I'm not quite sure how addiction works so I don't know whether that's a reasonable expectation. (33, male)

I don't know. All I know is that I've discussed this with doctors and doctors tell me that, GPs and specialists tell me, that it's not uncommon but I can't answer that X, I really don't know. Whether, see Mum was an only child and whether she ever saw my sister as a, some kind of a lifelike doll and my brother and I as something quite different, I really don't know. Am I making sense? (11, male)

Previous research reported similar findings in that 'unknowingness', perceived as a social phenomenon, added to their experience of depression (Feely et al., 2007).

Again, compatible with the principles of CBT, psycho-education would help the above participants to understand the nature of mental illness as well as the nature of family dynamics. That knowledge and understanding becomes the foundation of continued collaborative therapy to best help an individual with their particular problems.

To reiterate the importance of individual experience as explored in this study, another qualitative study found that older adults felt that doctors needed to explore their individual experience of depression grounded within their social context (Wittink, Dahlberg, Biruk, & Barg, 2008). Identifying symptoms and diagnosis was insufficient for that group.

Underachievement

Underachievement is included in this sub-theme rather than Stress at School, including Bullying, as the following quotes highlight the long-term negative consequences felt by a small number of male participants.

INT: *Okay so you did okay and you weren't disruptive but looking back you wonder if maybe you could have done better?*

Oh I'm sure I could have done better if only, I mean, even in those days I might have been suffering from depression and didn't know about it. (11, male)

Oh no, I hugely regret it. Again in hindsight, I mean, hugely regret it. Most of my current friends are graduates of one description or another. Funnily enough a lot of them are architects so my under education actually, affected me socially to this day. I find myself excluded from some conversations which hurts me a little bit actually because I feel that I could be included and still contribute but, you know, I have underachieved without question and you know, that's a huge mistake in life and at least I try to teach my own kids that one of the [?] things in life, one of the most important fundamentals of life is to actually achieve. It is actually what you get one of the biggest kicks out of. Yes, achievement gives you a big buzz and unfortunately I learnt that far too late in life. (24, male)

Whilst the first participant, 11 (male), was commenting on how he had underachieved, participant 24 (male) extended his observation to how it had affected his life detrimentally. It is not clear from my research whether there is an association between depression and underachievement. The first participant indicates that psychological distress occurred before or during his school years and might have been the cause of his underachievement.

Underachievement is not discussed widely in mental health literature. Research has associated it with attention-deficit/hyperactivity disorder (Stein,

2004) and social phobia (Lipsitz & Schneler, 2000). Certainly, the social consequences of underachieving are highlighted by participant 24 (male).

Summary

This theme explored patterns of thinking and behaviours which perpetuated the participants' stress and likely induced depressive symptoms. Some of the participants recognised these patterns as unhelpful. Others were recognised by the researcher as common factors and likely to be causing problems.

Poor coping strategies were evident. Some recognised that their coping strategies were not helpful while others continued to use strategies that maintained their problems.

Avoidance was the most common coping strategy employed by this group. Bottling, ignoring, shutting down, distraction, and procrastination were commonly used. Some internalized their stress for many years while others bottled it for a time until they could contain it no longer. The use of avoidance has different consequences for different cultures. Teaching detrimental effects of avoidant coping might be more useful than intervention focusing on teaching problem focused coping.

Four of the participants (3 male, 1 female) used alcohol as a coping strategy. Some recognised it as self medication, and others did not relate it to their depression. Research shows that when depression and alcohol-related disorders are comorbid, alcohol-focused intervention was more successful for men, and depression-focused intervention was more successful for women.

Participants who experienced breakdowns were male. Research more often reported males connected to breakdowns. However, much of the research was with men only, and common was the relationship to work stress. Interestingly, participants' parents reported to have breakdowns were four mothers, no males.

Suicidal ideation and suicide attempts were experienced by almost half of the participants. Contrary to much research, the majority were males. Concurring with research on bullying, most had been bullied at school.

Poor communication was identified as problematic. For some the poor communication lay with the participant. Others had difficulty with others' poor communication. The participants who highlighted poor communication with their parents went on to have poor communication as an adult. Some showed internalizing symptoms of poor communication such as shyness and lacking confidence while others showed externalizing behaviours such as fighting and bullying. For many, poor communication resulted in loneliness as they had difficulty with interpersonal relationships.

Prevalent in this group was the tendency to view themselves, others or the world around them as negative. Most had feelings of self-criticism, self doubt, inadequacy, failure, and worthlessness, with some having clear core beliefs of failure and being worthless. Many had negative feelings or expressions towards others such as blaming, bitterness and resentment. The most common recipient was a sibling. Such negative perceptions are commonly associated with depression.

In addition, this theme included a sub-theme which highlighted what participants discussed as having been unhelpful, as well as aspects not discussed in other themes or sub-themes which the researcher noted might have been unhelpful.

A large number of the participants found aspects of the helping professions to be unhelpful. Half found talking therapies to be unhelpful including varied forms of counselling. Highlighted were the importance of understanding individual experience and a need for health professionals to use a style of therapy which best fits the individual presenting with depression. Additionally, the importance of instilling hope was highlighted. More than half found medication to be unhelpful.

A small number of participants suggested advice was unhelpful and the same number of female participants discussed stigma as being bad and detrimental. Stigma was experienced and defined differently by each participant. The researcher noted that a few male participants lacked understanding of mental illness, addiction or family dynamics which might impact on their recovery.

Lastly, a small number of male participants acknowledged underachieving at school with some noting the long-term consequences and regrets associated with this. Underachievement is more often associated with ADHD and social phobia than with depression.

Chapter 11

Positive Perceptions and Assessments

Amidst the negative themes was a clear indication that all of the participants had positive perceptions of some aspects of their lives. Features of this theme were woven throughout from early childhood memories, through the (DIS) and on to having positive aspirations and hope for the future. Some participants conveyed positive childhood memories, including happy memories of their parents, while others tended to have some positive memories interspersed with negative events or perceptions. This theme explores all aspects of what the participants discussed as positive, helpful and/or important in their lives ranging from caring for others, believing in positive attributes about themselves, how some found the questionnaires from the DIS helpful, what aspects of past professional involvement helped, to all of the participants feeling happier since the DIS with positive aspirations for the future.

It is important to include this theme in the study. To enable a complete understanding of depression from the participants' perspectives, all aspects of their experience, including positive aspects, need to be explored.

Due to the broad-ranging nature of the theme, it has been reported under a number of sub-themes to enable clear reporting of factors which were described as helpful and/or important by the participants. In addition, to enable a clearer view of timelines, and perhaps understand the perceived improvement from the participant's perspective, positive perceptions pre the DIS have been reported separately from post the DIS. The sub-themes are *Pre Dietary Intervention Study*, *Post Dietary Intervention Study*, *Helpful/Important to the Participant*, *Helpful Attitudes and Actions by others*, and *Professional Help*.

Pre Dietary Intervention Study

Prior to the DIS, all of the participants had a range of positive memories. The majority noted some sort of positive attribute about themselves, such as having

leadership qualities, being an optimist, being capable, confident, fortunate, assertive, and being proud. Examples include:

I joined the Christian Youth, the group at school and I ended up leading it because I'm the kind of person who doesn't do things by halves so I ran it and that gave me a confidence boost too because I was speaking in front of groups of people too, you know, with notices and you know, we would have planned activities and I was running that and that was also a boost to my confidence. (69, female)

INT: *And you said you left school when you were fifteen and you got your first job as telegraph boy. How did you feel going round doing that?*

Oh proud. Proud. A uniform, a hat, you know. Pushbike. (12, male)

Oh yes, definitely and I think now that I've learnt, I'm the kind of person that I realise I've learnt now that I'm a thinker and I'm a person who can write things and since learning that too, I've written poetry and I've won contests for poetry overseas and I know that I can do these things but I know what I can do. (6, male)

The majority of the participants discussed positive aspects of their lives and good memories. For some it was happy feelings when they were growing up, some were happy memories of events, and others were about remembering the good things rather than the negative aspects. Examples include that they felt secure, special, having a charmed life compared to others, that independence was encouraged and was discussed positively, and that the participant was happy with his nature.

Yeah and I felt like I was the favourite girl (laughs). I felt like I was special. (67, female)

Because, things have always come easily to me. [Brother], all through his life he had to struggle because he was sort of insignificant or, what's the word, kind of meek. People wouldn't notice him and he would miss out on stuff all the time and you know, the classic thing was he didn't get accredited UE so he sat the exams, passed them all, went back really proud of himself and no one had noticed and they put him in the second year sixth form. That's the sort of thing. It happens now and then to [brother]. It doesn't happen that much any more. Yeah. I have led a pretty charmed life really which makes my life even more ridiculous so yeah, I think that's how [brother], yeah, he would see me as fortunate and fairly competent because I could always do things that required coordination and practical things. (33, male)

I can't remember too much about it but I remember we were all pretty happy, you know, but again, when I look at it, like we all got equal at that stage we all got an equal amount of stuff. (6, male)

Less than half of the participants had positive comments to make about their time at school. Only one noted that bullying was never a problem for her (82, female). Some talked about enjoying school and being motivated when studying as a positive occurrence. Others discussed their high achievement in earlier years but it was not uncommon in this group for the high achievement and enjoyment of school to diminish during college years.

Um, yeah, I found school good. I enjoyed school. (82, female)

Primary school was good. I liked it. Yeah. I got to know people in the village and we would go out playing netball and had like a club after school, a crafts club and I was quite brainy. An early developer like I was miles ahead of all other kids. But all the other kids came from bad backgrounds though and I was, compared to most people, I had quite a

good family and I was two or three years ahead for my age but when I went to the secondary school I realised then I wasn't. I was probably just average. (67, female)

Oh at times pretty well. I think I was sort of top of the fourth form and then truancy sort of took over in the fifth form.

INT: *Oh okay. Had a change of heart?*

I had a big change of heart and I passed School C without doing any work at all. I got lucky with one or two subjects and kind of predicted the questions that were going to be asked and got ninety odd percent in geography for example. Yeah, the sixth form was a different matter. The ratbags wouldn't give me UE because I was never there, among other things. (24, male)

Until, until the sixth form I found it all pretty easy really and then started getting hard so I gave up. I went to university from the sixth form and found university, the stuff I was interested in, really easy. I had kind of lost the plot with maths by that stage but academically at school I always did pretty well but I would generally have comments on my reports that I wasn't very tolerant of other people that weren't as smart and I can remember that. (33, male)

Additionally, half of the participants talked of having positive friendships during their school years, many of which have continued into adulthood.

Um, I always had a core group of close friends and those were the ones that I could easily bike to normally. As I got older, you know, I've always had either one or two close friends and then there's been a circle of friends and that's still the way it is today. Oddly enough, I don't keep in contact with many of the people I went to primary school and high school with. Probably because a lot of them stayed in the district and of course I moved

away. Yeah and they're out of town here and things like that, yeah. (82, female)

INT: *Okay so you've still got friends from there? What about from high school?*

Yeah. Quite a few. There was probably about six of us that keep in touch almost every week and you can probably bet just about every day as well. (21, male)

Most of the participants had been in a relationship, many married and some married more than once. However, the majority of these were listed in the PHQ-F as an event that happened in a time frame with no information regarding the positive aspects of the relationship. Only two participants specifically discussed their relationship in positive terms, one commenting “We’ve got a good relationship” (11, male), and the other stating that “a relationship is hugely good for me” (24, male).

As with the positive perceptions of parents in the theme Negative Attachment Styles, one can only speculate as to the reasons for the positives. Perhaps it is normal in a semi-structured interview situation to glean both negative and positive reflections on life, particularly when the participants are no longer depressed, as discussed in more depth in Chapter 9.

It is not uncommon in depression research to focus on the negative aspects. It is also not uncommon for depressed individuals to have difficulty remembering positive aspects (Moyle, 2002). However, some research reports on the more positive aspects of an individual’s life, usually pertaining to recovery (e.g. Leedy, 2009; Ridge & Ziebland, 2006). Participants in the current study reflected on recovery aspects in the following sub-theme.

Post Dietary Intervention Study

All 13 participants discussed improvements in their happiness, lifestyle, and/or outlook since the DIS. These included enjoying music more, sleeping better,

exercising more, being less angry and bitter, assertive, confident, calmer, having addressed their drinking problem, planning an overseas trip, thinking more positively, and feeling “normal” now.

I think that I feel happier about life itself. That's the, that's hard to, hard to explain except in those words. Life is, when I feel life is worth living, it's really worth living as opposed to just existing.

INT: *Right. So the good times aren't half hearted good times?*

What I'm talking about is listening to music really. You know, I really, really enjoy it and mucking around with the computer.

INT: *So just getting more out of the simpler pleasures in life?*

Yeah, yeah... (1, male)

INT: *Okay, so if you were going to sum up how things are different for you now than they were before you began this study, how, what would you say?*

I would say calmer and peaceful and loving. (6, male)

INT: *Have you made any changes in the past year to your life style?*

I've started going to the gym so that means I'm getting regular exercise. I think that helps my mood. Makes me feel a bit happier. (66, female)

Yeah, it did. Um, I was having problems with drinking. Being in the study made me want to do something about that because I had to be reasonably honest about ... yeah. (82, female)

Exercise has been known to improve depressed mood (Leedy, 2009). Therefore, it is not surprising that participant 66 (female) experienced a “happier” mood after going to the gymnasium. Likewise, alcohol and depression have been found to be correlated (Meririnne et al., 2010; Ogasawara et al., 2011) and it would be hoped that a reduction in alcohol consumption for participant 82 (female) would likely improve her mood status.

Not only were the participants feeling more positive and happy post the DIS, the majority had positive aspirations for the future, further indication that their depression had lifted. Compared to shutting down, being suicidal, and negative thinking apparent in the participants at the beginning of the DIS when positive aspirations were not apparent, current positive aspirations and hope constitute a major shift. As discussed in Chapter 10, hope was an important aspect of the recovery process. It is possible that hope was instilled in these participants simply by being involved in a study aimed at helping individuals with depression.

Most participants suggested one or two minor changes such as having more money, a bigger house, or getting a new job. A minority wanted more changes, for example, having less stress, better coping skills, see the grandchildren, older children to move out of home, and sell up and move back to the city (12, male). Examples of aspirations include:

I don't know that I would. I think I'm pretty okay at the moment! I mean, my relationships with my family are reasonable. My relationship with my new partner is good. It would be nice if that was still going strong in five years time. It might be nice to be working a little bit longer because I'm still doing four days a week although it is great, you know, having days off. From that aspect the money is more the issue there than the illness or the time off sort of thing. Yeah, no, there's not a heck of a lot I would like to change. (82, female)

Something to look forward to, yeah. Something we are doing because as I said, our youngest is just turning fourteen. Well he's pretty all right to leave with someone now if we wanted to go for a trip. The rest are all self sufficient. (12, male)

I think I would like to have a bit more money and perhaps I would like to live in the country so my daughter can have some animals and things. Otherwise we are fairly happy. I would like a bigger home and perhaps

have a bit more money to go on holiday and things. I'm not really that ambitious any more. (67, female)

Again, interviewing previously depressed individuals likely influences their state of mind, or helps draw attention to the positive changes they have made, the contrast between then...and now.

Some of the participants recognised the need or desire for less stress in their lives and better coping skills, indicating that they recognise the problematic nature of stress and the benefits of good coping strategies.

Helpful/Important to Participant

Of particular interest with the current study is that the DIS was not a clinical trial but a double-blind study. The DIS compared the effects of omega-3 fish oil to a placebo of olive oil. Researchers were specifically advised not to enter into a therapeutic relationship with the participants. Yet aspects of that study appeared to be helpful and had a positive effect on the individuals as depressive symptoms abated for all individuals during the study, the majority of whom maintained the improvements at this one-year final phase. This and the following sub-themes include the exploration of what aspects of that study might have been beneficial for the participants as well as any other discussion regarding what the participants had found as generally helpful over the years. It is important to include this information as it will help direct future research into more effective treatment pathways for depression. Additionally, it may help guide clinicians in their choice of treatment pathway and their therapeutic style by deepening their understanding of the diversity of what depression and recovery means to different individuals. Furthermore, it removes the temptation to explain the overall improvement in depressive symptoms in the DIS merely as a placebo effect by understanding from the participants' perspectives what they thought was helpful beyond taking a supplement.

There were a number of things that the participants described as being helpful for them. These ranged from caring for others, things that they did for

themselves such as activities, the use of distraction, relaxation techniques, lifestyle changes, and learning to like who they are, to attitudes and/or actions by others such as support, empathy, being listened to, and having someone to talk to.

Care for Others

The majority of the participants noted or modeled the desire to help other people. This was demonstrated in a variety of ways such as noting it as important on the PHQ-F, describing care for others, benefiting others, and how being responsible for others was helpful. More than half of the participants noted the importance of helping others on their PHQ-F. This was reported when asked what they hoped to achieve by being involved in the DIS, and when reflecting on their involvement in the study. Many also discussed this as important in their interviews, for example:

probably hard to say but I think the main part why I done it is to help other people because I mean I feel I've been through a lot but I have not been through nothing what other people have been through. (6, male)

...the thing that's come out of the study is that I, my participation with the study is that hopefully I have given some help to X and yourself and other people that would help other people. (11, male)

Um, it was good being part of something that I knew would eventually, would help other people, not simply myself if I ever needed it. Yeah. (69, female)

Some of the participants who did not explicitly discuss the importance of helping others by being part of a study showed it in other ways. For example, being responsible for someone else was found to be helpful for the following participants.

Yeah, yeah. I mean I look after my nieces and I believe I have a beneficial effect on them and I'm also able to monitor their welfare and make them feel safe. (1, male)

...but finally settled into [my career] and then kind of crashed into or fell into marriage and kind of being responsible for, or at least being responsible for a relationship is hugely good for me because at that stage I seemed to be able to pick up my direction and set myself some goals and I sort of embarked on a career path that (a) was incredibly enjoyable and (b) was upwardly moving so and we were having a family which is of course, a joyous occasion so none of those years from the age of perhaps twenty-two or twenty-three through to the age of whenever it was, forty-fiveish, were, well, were great years. (24, male)

Whilst caring for others is discussed in a positive light and could be considered altruistic, such behaviour was found to be less favourable in the study by Feely et al. (2007). Personal characteristics of depressed participants in their study commonly included 'people pleasing behaviours' and 'the inability to say no'. Some participants recognised these characteristics to be detrimental to their mental health. Reasons included a sense of diminished self-worth as they were aware that they put the feelings of others before their own. On the other hand, some participants experienced an increase in self-worth when the motivation was not to please others but to know that their actions contributed positively to others' lives. Although this was not the specific phenomenon currently being studied and therefore deeper questioning regarding feelings pertaining to caring for others were remiss, the above quotes indicate positive experiences when caring for others. Furthermore, equally helpful and important for this group was the desire to support research, give back to the medical profession and be part of research that had the potential to help themselves and others with depression. This information was gleaned from the PHQ-Fs as well as taking first choice in what was the most helpful aspect of the study in Reflecting on the Research Study. This type of

desire to help others did not indicate negative feelings in return for the participants' caring attitude or actions.

Activity/Distracton

More than half of the participants found some form of exercise, activity or distraction to be helpful. Examples included exercising, joining a club, keeping busy, focusing on something else, using a punch bag, being more motivated when studying, and collecting things. This information was gathered during general conversation as well as when the participants were asked what advice they would give to a friend with depression.

I think it's the fact that I get out of the house. I go and do something for an hour or two. I do some exercise so I feel like I'm achieving something for fitness and it's just something nice. I get away from everybody. There's no one to annoy me or to have any demands on me. It's my time I leave my cell phone away and no one can get to me so it's just the mental space as well so you can, if I've got an issue about something I kind of think it through while I'm on the treadmill and things. That's quite good for just that space, that no one can invade it. It's my time. (66, female)

You know and the biggest thing I actually got into when we were young was collecting and I had a massive collection of things when I married my wife and that was the main thing that kept me going, you know, like I says, they [parents] didn't like anything. (6, male)

The other way we go round it too is if I start to get a bit down I say "[Wife], lets go" and we have a coffee somewhere. (12, male)

Similar to distraction or activity is work, which one third of the participants noted to be helpful for them, for example:

It makes me get up each day and get to work whereas I would think that the time that I was on my own, it was a lot easier just to sit for the day and not do anything. If I've got a time limit I will get a lot more done than if I think, well, I've got five days to vacuum the floor so it can always be put off until tomorrow. (56, female)

Oh hugely. Again the social contact, the feeling of achievement in all those work situations, you know, I was getting positive feedback which is important to me and is presumably important to everybody and the social contact and the feeling of worthwhile-ness you know. When you are sort of sitting at home and doing nothing more than the dusting and vacuuming and cooking, you get the old housewives neurosis. You wonder what the hell you're doing really. Tried a little bit of volunteer work but - during that period as well. (24, male)

Much literature on coping with depression focuses on causes, gender differences, and dysfunctional coping skills (e.g. Danielsson & Johansson, 2005; Wilhelm et al., 2008), similar to findings and discussion in Chapter 10 which focused on unhelpful and maintaining factors of depressive symptoms. However, participants in the current study showed knowledge and insight into many positive helpful coping strategies which they considered had been successful for them.

It is possible that participating in the study somehow fostered a sense of recovery possibilities. In their research on the meanings individuals give to recovery from depression, Ridge and Ziebland (2006) discussed the importance of recovery language to enable the healing process to begin. For some of their participants, depression had been a part of their life for so long that recovery had not occurred to them and they had no insight into what recovery meant or looked like. Once that possibility had been fostered, for many, healing began.

Similarly, Ahlstrom, Skarsater, and Danielson (2009) found that, from other family members' perspectives, despite all the difficulties of living with someone

with depression, most discovered positive ways of coping to improve their situation.

We may not discover what triggers the healing process. However, this and previous research highlights to clinicians the importance of instilling hope and fostering the idea that recovery is possible. Furthermore, participants in the current study demonstrate that individuals often have successful positive coping skills available to them from their own experiences. Clinicians can draw such positive coping skills to the depressed individual's attention and promote their growth. Additionally, exploring and fostering positive coping experiences of significant others will likely yield positive results in therapy.

Social Interaction

As well as activities, almost half of the participants acknowledged the need for social interaction and that being around people helped avoid depressive symptoms. One participant noted in his PHQ-F that he biked by himself a lot around New Zealand at which time he realized that he was not a "loner" and "gets badly depressed if cut off from people" (33, male). Other examples of the need for social contact are:

*I wasn't getting enough social contact. I was far too isolated and insular.
(24, male)*

INT: *Does that make things better for you, to make friends?*

Yeah, it does. A little more social interaction. (66, female)

As seen from discussion in previous chapters, many participants had a tendency to withdraw from social interactions for various reasons leaving them feeling isolated and lonely, not an uncommon result of depression. Yet this very withdrawing maintains the depressive symptoms. Again, the reasons for withdrawing must be explored. Should social phobia be apparent, insight and knowledge alone, as shown by the above participants, might not be sufficient

without work on maintaining factors of social anxiety such as avoidant coping, as well as exposure therapy techniques.

Stress Relief

Half of the participants reported various forms of stress relief to be helpful including time out, anticipating change, being assertive, and relaxation techniques such as breathing techniques. Therapies akin to CBT generally include a relaxation component because of its proven helpful qualities.

INT: *So, learning to deal with change and knowing what's coming up and anticipating those changes will make things easier for you?*

Yeah, it makes it easier because I don't get so stressed about it. (66, female)

I try a lot more to relax now. I try very hard not to get involved in the children's problems at home and planning to go, [wife] and I are planning to go overseas for a trip next year... (12, male)

Time

Nearly half of the participants acknowledged that change and healing took time and that it was important to be patient and take "one day at a time" (33, male; 66, female)

Time seems to have been the healer and I say time, over the six years I went untreated I was gradually, and having been removed from the stressful environment I was gradually, very gradually, improving. (24, male)

It has been said that depression will abate over time, regardless of whether help has been sought or not (Schreiber, 1996). However, this can take months or even years, as with the above participant who called time the healer. Was it time or was it the removal of the stressful environment he also makes mention of? Without doubt, stress has been implicated as a major cause of depression in this study. It

would be expected then that the removal of such stress would reduce depressive symptoms. With guidance, this can be done without the need for individuals to continue suffering depression until time supposedly heals.

Positive Support

The majority of the participants discussed having been supported in a positive manner and some noted it as being important for their wellbeing. Support for this group came in the form of family including extended family, friends, doctor, and a small number commented on the support of the researcher from the DIS.

Go talk to your doctor about it and if they feel comfortable about it, talk therapy about some of the issues that may have set it off. Be honest with family and friends. If you can't be honest with both groups at least pick a couple of people to tell what's going on in your life and seek, try and build up a support network around yourself. That includes your doctors and your professionals but, you know, your friends as well. (82, female)

Having my wife there, who is a support, helps a bit. It's not everything because quite often she won't understand or sometimes you don't want to even talk to her about things. And also there's been a friend from church which, oh, not recently, but I used to go and have a chat with him every now and then and talk over things and I still do once in a while. (18, male)

As discussed in Chapter 8, lack of good support can result in feelings of isolation, loneliness, and symptoms of depression. Furthermore, good support systems were found to be related to less depressive symptoms (Mechakra-Tahiri et al., 2009). Participant 82 (female) had found talking to a health professional and building positive support systems to be helpful as this is the advice she would give to a friend with depression. Perhaps that support system might benefit from extending beyond a spouse or immediate family member as with participant 18 (male).

There were some things he did not wish to discuss with his wife. However, he appeared to find talking things over with a friend from his church helpful.

Insight

The majority of the participants demonstrated insight to some degree. Through such insight some participants had made changes accordingly. For example, one participant recognised that his anger was destructive and subsequently changed his behaviour. Others had insight but struggled to make changes. For example, one participant recognised procrastination to be his problem but had not been able to change that behaviour (1, male). For some the recognition appeared to be with hindsight when reflecting back in time.

I'm not too sure. Just a realisation that it was crippling basically. And it was completely and utterly destructive as opposed to constructive. I mean, let's face it, it was now ancient history and it was time I sort of dropped it and moved forward. (24, male)

... but in some ways also seeing that the things that I enjoy doing like withdrawing, reading and retreating into a fantasy world can also trigger the depression because that's my way of coping, is just by retreating. (56, female)

Therapy can be used to build on insight that an individual might already have, whether it is to provide further information to enhance their insight, or to help them change their behaviour such as procrastination when they acknowledge that they are stuck.

Diverse Findings

Positive factors that individuals attributed to themselves or found helpful were diverse. Other factors that this group found helpful and important, with a few participants in each category, included lifestyle changes, learning to love and

respect themselves, spending time alone, positive thinking, regaining personal power, recognizing a window of opportunity, and not giving up, with the advice being to keep seeking help until a solution that works for them is found.

...Umm and I think the biggest thing is too, they need to explore themselves. Once they've done all those things, they need to explore themselves. They need to find and one of the greatest things as I says to you that I says to people, you need to learn to love and respect yourself because if you don't you cannot find true love and respect in anyone else or anywhere else. (6, male)

To keep trying to seek help. To let them know that it's okay if it lasts long term. Well, that's fine. Everybody has got their own levels of coping and just to find a solution that works for you. To seek advice but then digest it and go the road that is best for you and to know that there is a time that's good for change and if you are not ready you can't cope with change, that it's okay if it takes a little bit longer. (56, female)

Helpful Attitudes and Actions by Others

In asking the participants what had been helpful for them and what advice they would give friends with depression, a number of attitudes and actions by others were identified as helpful or important. 'Others' include professionals, friends and family.

Talking Helps

All of the participants described talking to someone or being able to tell their story as being beneficial. This is beyond social interaction discussed earlier. Social interaction does not necessarily include the more intimate telling of their story of depression. Ridge and Ziebland (2006) found similar results when studying recovery from depression. Their participants described talking to health professionals as insightful and showing pathways of self discovery, resulting in

fewer feelings of isolation and loneliness. Many participants recommended talking to family and friends while others recommended talking to a neutral person.

The first thing I would say is find someone neutral you can talk to. Non-family member. That would be the first bit of advice. (6, male)

I think being able to talk about it. You know, the idea, because I don't you see, I keep it to myself and I have also tried talking it over with my doctor and also a doctor I have got here and it's clear cut they've got no bloody idea of what I'm talking about, you know because, you know, the first time I tried to talk about that problem, I mean, the psychologist gave me a book to read and that was just, I mean you had to be frigging stupid to come up with that as a possible solution to someone who's saying "I don't study". That book caused me heaps of problems! (1, male)

Yeah, I did talk to Mum and then I had a new doctor in Christchurch and she was really lovely and really supportive and talked to me a lot about what was going on and she was really awesome. Really helpful. (66, female)

Listened to

Closely related to talking to someone is being listened to without judgment which some of the participants noted was important.

It was certainly useful to me in that I liked X with whom I was doing the study. I enjoyed his company. I enjoyed his demeanour. X basically listened. A great listener. I can't recall X actually sort of giving too much advice but being able to unload a certain amount and have a sympathetic listener was certainly beneficial at the time, no question. (24, male)

I guess I've learnt in the last year, also, with problems that it's important to feel like you are being listened to and it's important to make other people, for other people to make you feel like your feelings are valid... (69, female)

In contrast to findings by Emslie, Ridge, Ziebland, and Hunt (2007) who found that women emphasized the importance of being listened to while men spoke of the practical ways health professionals enabled them to talk, four males compared to one female in the current study emphasized the importance of being listened to. Two males included that being listened to without judgment was particularly important. For example, participant 6 (male) suggested talking to a non-family member as “they’re not judgmental”. The other participant found chatting to the researcher from the DIS helpful as he listened with no judgment.

Whilst gender comparison research is helpful, sometimes it might lull clinicians into assuming what is important to a patient because of his or her gender. The current research has demonstrated more than once, results that are opposite to that of gender comparison studies.

Respect

Some of the participants discussed respect as being important, including mutual respect. Respect included respect for the self, respect for others, respecting cultural differences, and respect for a therapy programme (Alcoholics Anonymous (AA) - 12 steps). The last was discussed in terms of the participant not respecting the 12 steps of the AA programme and therefore did not find it helpful.

In the end I couldn't, I never got past that step where, so yeah, I do think I would find it difficult to, yeah, without respecting the principles; I think I might start to respect the principles if there was a positive change but without respecting the principles I can't imagine there being a benefit that I would accept or notice or there even being one but [?] said that does happen sometimes. (33, male)

Empathy and Trust

A small number of participants noted empathy to be of importance and the same number felt that trust was important.

Additional helpful and important attitudes and behaviours that individual participants noted included being accepted, being taken seriously, having clear boundaries, honesty, having hope, integrity, and positive learning.

Many of the above findings are some of the elements which aid the development of a successful therapeutic relationship which Moyle (2002) found to be important with her in-patient participants. All too often her participants found that the body was taken care of physically but little time was put into nurturing a relationship which fostered being listened to and understood.

Professional Help

More than half of the participants acknowledged various talking therapies as being beneficial including counselling, psychologists, mental health professionals, hypnotherapy, and a doctor because of the talking and support offered. With the exception of a small number of participants who had mixed experiences with helping professionals, these participants were not the same as the ones purporting that talking therapies were not helpful.

Counselling was the most common therapy utilised with the majority of participants who had tried it noting that it had been beneficial. The other forms of therapy were mostly discussed by one participant each.

INT: *Okay. You've had experiences with medication. You've also had some experience with counselling, yeah?*

Yes.

INT: *Was that a worthwhile experience?*

Both of them were worthwhile, yeah. (11, male)

I'm not sure about those anti depressants. I thought the counselling helped but I was on anti-depressants for six months but they gave me a lot of

headaches and nausea. They did help because when I didn't take them I used to panic. Whether it was a psychological thing I don't know.

INT: *In what way did the counselling help do you think?*

Oh just talking about my life. (67, female)

Psychoeducation

Many participants in this group discussed how learning about depression and understanding was helpful. Much of this understanding was based around the usefulness of psychoeducation for them and for family members and friends who have the potential to be support persons. As discussed in Chapter 10, 'unknowingness' contributed to the cycle of depression (Feely et al., 2007). Therefore, it could be expected that knowing and understanding might alleviate depressive symptoms. Following are examples of how knowing helped, and that help would have been sought earlier had they 'known'.

I think I would have liked it if I had got into therapy or something when I first got it so that I could have understood a bit more because I was just given pills and sent home and I don't think that's a very good way of dealing with it. (66, female)

Now I know better (laughs). It's there as a support rather than, you know, and I understand the workings of the condition more so, yeah. (82, female)

Medical Model

The same number of participants who found talking therapies helpful discussed aspects of the medical model as being helpful and/or important (five of whom had also found talking therapy helpful). The majority of these were because of their positive attitude regarding medication. For some this was discussed in terms of how medication helped them, and others recommended it under advice for a friend with depression.

...Those are the things that I would say to them, especially the medication because even though I never liked being on the medication, like the Prozac, it helped me a lot. It helped me through times when I felt I just couldn't handle it because it would keep me calm. (6, male)

It was twenty milligrams a day. It's all it seemed to take which just seemed to have an incredibly positive effect on me. It was just wonderful. The counselling and you guys were all contributing and I kept on saying to X "For crying out loud I feel I'm almost here on false pretences. I'm just absolutely going through the roof here." It was just all happening for me. (24, male)

Research comparing the benefits of medication versus talking therapies has often concluded that combining both results in better outcomes (Sadock & Sadock, 2007). This research was not specifically searching for such comparisons and it is not clear from the above quotes which might have been more beneficial, if any. What is clear is that all 13 participants discussed talking as being helpful whereas only some of the participants discussed other aspects and medication.

The Dietary Intervention Study

A large proportion of the participants found the previous study helpful and most articulated aspects of that research which they found helpful.

Half of the participants found filling out the questionnaires helpful. Mostly, they were described as thought provoking which enabled them to discuss what was making them feel like that at that time. For one participant, seeing an improvement on the graph was necessary and helpful.

Yeah, and the study made me able to look at things because you had to say how you were feeling over the last month, fortnight, you know, it made me realise that okay, I had a bad day then, what did I do about it. It brought things to a conscious level rather than just being unconscious.

INT: *Okay. So the act of filling out those forms was ...*

Was a positive experience, yeah. (82, female)

I guess, just thinking about how I approached it, guess I'm sort of looking or expecting some sort of little improvement within a week or two I guess. Stuff like, with new drugs, maybe a month before they start to kick in so yeah. I'm aware of that and don't expect drugs to work any sooner. But also, I guess over time, over a period of several months I need to feel like, not that's it's been a steady improvement necessarily but that regardless of where the line on the graph has been between then and now that now I can look back and think I'm a bit better than I was. (33, male)

Filling in questionnaires appeared to bring aspects of the participants' depression to conscious thoughts, enabling them to acknowledge and understand some of their feelings and actions. Furthermore, watching an improvement on a graph throughout the weeks likely helped to further instil hope for the future and demonstrate that recovery was a possibility.

Some of the participants discussed the attitude of the researcher and the helpfulness of a good alliance, as well as the support of the researcher being first choice in Reflecting on the Research Study. This reiterates the importance of building a strong therapeutic alliance which, as shown in these findings, is necessary before any therapeutic change can take place. Beyond building rapport with the participants, being supportive, and listening, the researcher for the DIS had no further involvement and did not attempt therapy per se.

Clinicians must work hard to ascertain what is important to individual clients. This includes being aware of what they are saying and what they are not saying. What they are not saying might be a key to therapeutic change considering the avoidance seen in these participants.

Summary

All of the participants, as ascertained from the interviews, PHQs, and Reflecting on the Research Study, had various positive perceptions and assessments of life events.

Much research on depression focuses on negative symptoms and causes. However, all of the participants outlined positive memories pre- and post- the DIS. The majority noted positive attributes about themselves such as being an optimist, having leadership qualities, and being proud. The majority also talked about positive memories such as feeling secure, special and charmed. Half of the participants had memories of positive experiences at school and the same number talked of having good friendships at school, some of which have continued into adulthood. Relationships were noted and a small number were discussed in positive terms. It might be normal in semi-structured interviews to bring together both negative and positive reflections on life, in particular, when the participants are no longer depressed.

After the DIS, all of the participants talked about feeling happier, enjoying more, having made positive lifestyle changes, and/or having a positive outlook for the future. Most had positive aspirations for the future, some looking for minor changes while others were more ambitious. Having positive aspirations was a major shift for these participants who began the DIS with negative thinking. Hope was an important aspect of the recovery process.

A number of things were discussed as being helpful and/or important to the participants. The majority noted that helping others was important to them and helpful for their wellbeing. Many discussed this in terms of why they were involved in the DIS; to help others, to support research, and to give back to the medical profession. Others were noted more subtly, for example having responsibility for others was helpful. Caring and responsibility was discussed in a positive light and included supporting research to help others with depression, indicating altruism on the part of the participant.

The participants were able to draw on many positive activities which reduced their depressive symptoms. More than half found exercise, activities

and/or distraction to be helpful. One third found that work was a positive experience for them. Nearly half discussed how helpful and important social interaction was to their wellbeing and half talked about various forms of stress relief as being helpful.

Almost half of the participants acknowledged that time and patience were required for healing. However, both time and the reduction of stress were noted together as being helpful.

The majority of participants acknowledged positive support from family, friends and professionals. The majority appeared to have insight into aspects of their lives that had not been helpful, some being able to make positive changes with such insight, others recognizing it but not being successful at making changes. For others the insight came more from hindsight on reflection.

The entire group discussed helpful attitudes and actions involving other individuals. All of the participants noted how helpful and important it was to talk to someone about their life experiences and depression. Friends, family and professionals were recommended. Alongside being able to tell their story was the importance of feeling listened to. Contrary to some gender research, being listened to was supported by more males than females.

Half of the participants talked about respect, mostly in terms of mutual respect between the participant and the listener. One participant discussed the need to respect the model of therapy being used for it to be helpful. A small number of participants each discussed other helpful attitudes and actions such as honesty, empathy, being accepted, instilling hope, and having clear boundaries.

Many discussed past professional help received. Over half found talking therapies to be the most helpful with counselling being the most common and regarded as beneficial. Many noted the importance of psycho-education and understanding.

Several participants found aspects of the medical model to be helpful (including five who found talking therapy helpful), mostly with reference to the benefits of medication.

Participants were asked what aspects of the DIS they found helpful. Half of the group found aspects of the questionnaires helpful, some because they were thought provoking and some because they found it helpful to have their progress graphed, fostering recovery. A few of the participants found the support from the researcher to be of benefit, and the relationship with the researcher to be important, reiterating the importance of the therapeutic alliance in fostering change.

Depressed individuals know what is important to them and clinicians must work hard to garner this knowledge and use it to help build a good therapeutic alliance, instill hope, and foster recovery. What an individual is not saying can be as important as what they are saying with avoidance being the most common coping strategy used by this group of participants.

Chapter 12

Limitations and Conclusion

Limitations

Unfortunately all research has limitations, the current research being no exception. Only 13 of the original participants from the DIS were available or accepted the invitation to be interviewed. Nevertheless, 13 were sufficient to enable an in-depth exploration of their reflections and draw upon common themes. Furthermore, fewer participants are considered preferable in qualitative research (Fischer, 2006; Gavin, 2008).

Analysing interviews conducted by another researcher had its limitations. For example, there were times when reading the transcripts that the current researcher would like to have explored a topic more in depth before guiding the participant on to the next line of questioning. Additionally, different types of follow-up questions might elicit different types of answers and there were times when the current researcher might have asked different questions to those asked. However, an advantage of the interviews being conducted by one of the researchers involved in the original study includes the rapport they already had with some of the participants, as well as their knowledge gleaned from the first phase of the original study which helped in designing this final phase.

Having others involved in the initial design of this final phase of the research meant that there were limitations to its design. Included is the design of the interviews, as well as limitations to the type of analysis used. For example, a grounded theory of analysis could not be used as analysis and interviews are conducted together under that methodology with further interviews being refined during analysis. However, these limitations were overcome by careful consideration of how to use all qualitative data available and which methodology was flexible in its design enabling an inductive, semantic approach to analyse data gathered by another researcher.

Even though the current study was not specifically studying gender differences, having more males than females offered an unusual perspective,

bringing to the fore some unexpected findings contradictory to other gender studies. However, the males in this study could be considered unusual in that they volunteered to be interviewed about their experience, perhaps indicating a certain type of male who might be more in touch with his feelings, or more able and willing to talk as he was on the path to recovery and no longer depressed.

Only a small number of individuals residing in New Zealand were represented in this study. Future research exploring depression in the New Zealand context would enhance and build on this base. This could include different groups of adults as well as include adolescents to broaden the age range and extend findings from this study which clearly indicated that psychological problems were already taking shape within this developmental stage.

As well as the limited number, this sample was a community sample of volunteers. Their experience of depression might be different from a typical clinical sample, for example, or those with depression who might not be willing to volunteer to participate in research. Therefore, the generalisability of the results could be limited.

As discussed, interviews can attract a positive response bias. To a degree this was countered by including the PHQ-Fs which enabled anonymity in filling out a questionnaire and showed some differences in response types as discussed in the findings. Future research of this type could be enhanced further by supplementing with self-report questionnaires such as the Parental Bonding Instrument (PBI) to enable an opportunity for participants to remain anonymous in their reporting of information. However, the PBI was not sustainable for the current research as it does not map so well to attachment styles, nor does it account for defensive styles such as anger or idealization (Anvin, 2004), both of which were discussed quite extensively. The inclusion of the Adult Attachment Interview would extend the current research by allowing a deeper understanding, exploration, and discussion including attachment styles which were discussed in the current research as possibilities but not confirmed. However, the AAI is a further interview process in itself which would be cumbersome to analyse alongside other interviews. Furthermore, interviewees might tire of such in-depth

interview processes. The development of a self-report adult attachment questionnaire which maps onto attachment styles commonly discussed would be of benefit to research of this type.

In addition, meanings of pauses, intonations, and body language were not always apparent. These emotional components, valuable in mental health research, might have offered a greater depth in some areas. Future research of this nature could make use of digital visual recordings to include these important aspects. However, it might be more difficult to obtain volunteers to be interviewed with this type of recording.

Despite the limitations of the present research, it has provided insights into the experiences of a community sample of participants who had experienced depression, improved during participation in a double-blind study, and had maintained that improvement in the final phase one year later. The process of reflecting back on their lives and experiences, and the insights obtained by doing this may not only have provided participants with increased self-knowledge and understanding which is therapeutic in itself, but their own insight into aspects of therapy which they found helpful or unhelpful, may provide premise for reflection and future research on the part of mental health practitioners.

Conclusion

With prevalence rates in New Zealand of 18% (Oakley-Browne, 2006), or possibly as high as 41% (Moffitt et al. 2009), it is essential that a more in-depth understanding of the experience of depression is obtained. An effective way to do this is to explore the experiences of depressed individuals. An even more effective strategy would be to explore the experiences of previously depressed individuals. This premise underpins the present study.

After listening to each participant's experience of their depression and their ideas of causes and maintaining factors, four main themes were identified: *Stress and Anxiety – Causes and Consequences; Negative Attachment Styles; Maintaining/Unhelpful Factors; and Positive Perceptions and Assessments*. A complete summary of the findings can be found at the end of each theme.

Stress and Anxiety

Stress and anxiety were prevalent and were considered to be the cause of depression by many of the participants. Perhaps the most significant finding was the pervasiveness of anxiety amongst this group. All participants displayed symptoms or behaviours which relate to anxiety, and all began at a young age. Therefore, depressive symptoms can be expected to follow (Wilhelm et al., 2008). Stress was found across themes including Negative Attachment Styles, seen in the descriptions participants gave of their earlier years such as participant 12 who listened to his father yelling while he sat on his bed crying in a room he shared with four others. Stress was also noted in the Maintaining/Unhelpful theme in the coping styles adopted by participants.

Considered to maintain anxiety, avoidance was the most common coping strategy used by the participants, mostly resulting in detrimental consequences. This study uncovered many different types of avoidance including bottling, ignoring, distraction, procrastination, and shutting down. Additionally, bottling took on different forms: internalizing distress for many years; and containing distress for a period of time until the pressure built to ‘blow up’ point. Although these are all forms of avoidance, it is likely that each type results in different consequences. Avoidant coping and its relationship to depression requires further research.

In addition, this finding and future research on avoidant coping are important for further development of psychological interventions for depression and anxiety. With the current study highlighting avoidance as being problematic and maintaining of dysfunctional coping, therapy encompassing or targeting emotional coping might be of more benefit. One therapy which is gaining recognition in the research world as being efficacious is Acceptance and Commitment Therapy (ACT). An offshoot of CBT, ACT concentrates more specifically on experiential avoidance with the premise that accepting the unpleasant feelings and emotions is not as bad as our thoughts might predict (Blackledge & Hayes, 2001). Recent research confirms its effectiveness for

anxiety and depressive disorders, as well as alcohol disorders comorbid with depression (Forman, Herbert, Moitra, Yeomans, & Geller, 2007; Petersen & Zettle, 2009; Shallcross, Troy, Boland, & Mauss, 2010). However, the research base remains small.

Closely related to the experiences of my participants, Shallcross et al. (2010) found ACT particularly helpful for individuals faced with emotionally challenging life stressors. Individuals receiving ACT responded with decreased emotional reactivity and lower levels of depressive symptoms. Further research on the effects of ACT for depression is warranted.

Avoidant coping was likely learned in childhood. Many spoke of emotional abuse and poor communication styles within the family of origin. Avoidance might be an expected consequence of unwelcome experiences such as abuse. Furthermore, it might be a reason for poor communication and problematic relationships, perhaps an avoidance of confrontation. Additionally, anxiety was apparent in some parents of the participants, in particular mothers, indicating the likelihood of avoidant-coping being modeled in parents.

Problematic relationships continued for the majority of these participants throughout school and into adulthood. Most of the participants described problems such as not fitting in and being bullied at school. Feelings of not fitting in can be associated with shyness and social anxieties for which many suffered.

Findings Pertaining to Males

With more males than females in the current study it might be expected that some findings might relate only to males and not to females. However, some of the findings specific to males were opposite to what would be expected from previous research.

Suicidal ideation or attempts were experienced by close to half of the participants, most of whom were males which contradicts most research in this area. The current research indicates that suicide was more likely related to being bullied at school (in agreement with research on bullying) rather than being male or female.

Breakdowns and suicidal ideation or attempts, as evidenced in the current research, are further indications that an individual is not coping. Regarding breakdowns, all were males in this study as with other recent studies. However, parents who were described as having experienced a breakdown were all females. Should breakdowns be the consequence of depression, it would be expected that more women than men would experience them as twice as many women are reported to experience depression (Sadock & Sadock, 2007). It is speculated that women might experience symptoms akin to a breakdown but manage to hide many of the serious consequences when not in the work force. This opens up opportunities for future research regarding breakdowns beyond consequences that cannot be covered up such as not being able to continue with employment.

The use of alcohol was not excessive in the current study but was evident all the same, again, mostly by males. Recent research concluded that when alcohol-related disorders are comorbid with depression, men and women respond to different treatments (Baker et al., 2010). For men, an alcohol-based programme was more effective, while for women concentrating on the depression reduced both depressive symptoms and alcohol use. Future research could confirm and extend on this finding to further aid best treatment pathways.

Lastly, contradicting previous research by Emslie et al. (2007), more males than females described the importance of being listened to without judgment. Men are often considered to prefer practical help while women prefer to be listened to. The current research, again, reiterates the importance of assessing individual experience, and that men and women benefit from non-judgmental attention.

Positive Perceptions

Much literature on depression concentrates on the negative aspects and treatments with less consideration of positive memories and attributes which an individual might offer. Perhaps this relates to the difficulty depressed individuals have in remembering happy times or feeling anything but sad. Participants in the current study all articulated positive aspects of their lives and their parents (in particular fathers), whether it was from their younger years or after participation in the DIS.

Explanations for the positive memories and perceptions described by this group include the possibility that individuals who are no longer depressed are more able to remember happy times, 'dismissing' adults idealizing their parents, semi-structured interviews and the types of questions asked might be more apt to encourage the telling of happy memories, or it could be a positive response bias sometimes seen in face to face interviews. Certainly, all participants were more positive about themselves and life one year after the DIS compared to before they participated in the DIS. Regardless of the reasons, positive information is important to help clinicians choose treatment pathways, and help direct future research.

Future Research

Further to future research suggestions above (avoidant coping and its relationship to depression, and best treatment pathways for alcohol addictions), results from the current research have highlighted areas of research needing attention.

The majority of participants did not consider anti-depressants to be the best treatment option. Apart from a few who found medication helpful, many participants did not like the side effects of anti-depressants, did not find them helpful for their symptoms, and felt that they were prescribed inappropriately. This suggests that the current medical model of depression might be insufficient to conceptualize and guide treatment pathways, and a social or experiential model might be more appropriate. Health professionals prescribing anti-depressants would benefit from research aimed towards understanding individual perspectives and the meaning attributed to the use of anti-depressants by individuals.

Stressors common to the participants were traumatic incidents, often in the earlier years (the majority being in the 5-15-year age group), often multiple, and often cumulative, impacting on stress levels. Childhood illnesses, although not common to all participants, highlighted the need for further research into its long-term psychological effects including the most beneficial level of disclosure of information to the child regarding the illness and invasive medical procedures.

Apparent from this and other research is the need to address bullying in schools. Reacting to it after the incident, the current most common means of dealing with bullying is not sufficient. With bullying continuing from generation to generation a more proactive approach is required. Previous research has found that teaching effective coping skills in a school-wide programme reduced bullying (Lodge & Feldman, 2007). More specifically, teaching the detrimental effects of avoidant coping, commonly used among these participants, and how to reduce avoidant coping strategies might be more beneficial than focusing primarily on promoting problem-focused coping according to Lewis and Frydenberg (2004). Future research should take into account the cost of a school-wide programme, considered too expensive by some, compared to the cost to individual health and society of the long-term consequences when no such programme is implemented.

Highlighted in this study was an association between anger and being bullied. Previous research often focused on the association between aggression and bullying, and aggression and anger related to bullying, usually within those who were identified as the bullies. However, aggression was not apparent in these participants, and these participants were the victims of bullies. Focus on the association between anger and being bullied is a topic open for future research.

Sibling relationships are an area not well researched. Discussion of findings in this study uncovered little research exploring communication styles of siblings and the long-term effects that these styles might have on other family members. Additionally, a small number of siblings were reported as having a mental disorder, an area not well researched in terms of genetic expectations or consequences for other siblings.

Very common among both genders was the tendency to view themselves and the world around them negatively. Self-criticism, self-doubt, inadequacy, failure, and worthlessness were common emotions held about the self, with blaming, bitterness, and resentment commonly felt towards others. Self-criticism has been identified as a personality trait commonly associated with depression (Campos et al., 2010; Luyten et al., 2007), usually more evident in women. It has also been found to impede the treatment of depression (Marshall et al., 2008),

encouraging future research to further explore the effects of self-criticism, and how best to change the behaviour to aid development of successful treatment plans for depression.

Participants in the present study also described, as causes of their depression, a number of phenomena which clinicians will frequently list as symptoms of depression such as worry and anxiety. This perhaps suggests a level of circular causality depending on whether one is the person experiencing and living the depression, as opposed to the observer or therapist treating the depression. A suggestion for future research would be to look at some of the major psychological theories of depression and attempt to deconstruct them from the perspective of both the depressed and the therapist in an attempt to gain fresh insights into enhancing treatment by enhancing engagement and understanding of phenomena from the patient's lived experience as well as the therapist's perspective.

This research has highlighted difficulties with the current medical model of depression by exploring causes and influences from the perspectives of previously depressed individuals. Results show an inclination towards the usefulness of a model which addresses social factors, sometimes long-standing, and the context in which the depressive symptoms occurred. Future research could expand on these ideas towards developing a model of depression such as a social/contextual model which might be more helpful in terms of guiding treatment pathways.

Clinical Implications

The pervasiveness of stress and anxiety in individuals diagnosed with depression highlights the importance of not only assessing the possible comorbidity of anxiety and depression, but to assess whether anxiety was present first and might be driving the depressive symptoms. Indicated from this and previous research, treatment including psychoeducation regarding anxiety and avoidant coping might be more effective at reducing depressive symptoms. In addition, assessing social anxiety should include history, how an individual forms and maintains relationships, and what coping strategies are used.

Anxieties are common in children with learning difficulties (Koulopoulou, 2010; Missaoui et al., 2010) which some of these participants experienced. Both anxiety and depression, but particularly anxiety, are frequently under-reported by parents of children with learning difficulties (Koulopoulou, 2010), indicating a lack of understanding of its presence and effects. This likely extends to significant others such as teachers, relations, and caregivers. When treating a child for anxiety or depression, it is important to extend psychoeducation to include significant others and increase the awareness of those disorders.

Relocation was common within participants in this study. The greatest loss for individuals who relocated was an often diminished or depleted support system. Support was highlighted as a key factor for coping with stress and the common consequences described were loneliness and isolation. Of benefit would be help to rebuild a support system. This might include improving relationships with family and friends, or building a new support system in the community. Additionally, assessing communication and coping skills might uncover styles which are detrimental to an individual in maintaining relationships and, therefore, support.

Problematic relationships were a common cause of stress, also resulting in feelings of isolation and loneliness. Culture changes the problems encountered, with New Zealanders being inclined to end unhappy relationships whereas some cultures are expected to remain in an unfulfilling marriage. Highlighted is the importance of cultural considerations during assessment, beyond biculturalism, which may impact on an individual. Furthermore, should clinicians actively manage marital and relationship problems, depressive symptoms are likely to decrease.

Problematic relationships in adulthood appeared to follow problematic childhood relationships with parents and siblings. Communication difficulties and conflicted relationships were prevalent in the family of origin as were being overprotected and the encouragement of dependency. Overprotection was common among those participants who had been bullied which concurs with previous research. Treatment of depression when dependency is apparent can be

difficult. Highlighted is the importance of assessing communication styles as part of a clinical assessment.

Finally, it seems pertinent to draw together aspects of the last two themes which participants perceived as being helpful or not helpful. Clinicians can use this information to help guide their practice, in treatment and in relationship building. Some aspects are individual experiences, reiterating the importance of exploring individual experience in depression assessment and treatment. Others are common experiences amongst all or most of the participants.

All participants found talking to someone about their life experiences and depression to be the most helpful. Friends, family, and professionals were recommended. Content included symptoms and individual experiences, with being listened to and gaining an understanding of their depression being considered particularly helpful.

Those who did not find talking therapies with professionals helpful describe specific reasons which can aid clinicians in decision making regarding treatment. The information is gleaned from individual experience, reaffirming the necessity of taking time to understand each individual from their unique perspective, and realising that one treatment does not fit all. An example from this study includes the male participant who was given a book to read to help him overcome procrastination when the problem he presented with was an inability to study! Seven years later when he finally managed to read the book he did not agree with the content. Another example is the participant who tried group therapy more than once and did not find it helpful. Individual therapy might be more appropriate in that instance regardless of what research says. Being offered no sense of hope was another example discussed. The installation of hope is known to be an important element of assessment and therapy (Ridge & Ziebland, 2006). Stigma was detrimental to some participants and held different meanings, depending on the individual. It is important that clinicians clarify what an individual means when they mention stigma. Stigma might be reduced if terminology reflected individual experience more closely. For example, grief, low mood, loneliness, and having low self-esteem might be less daunting and more appropriate than calling it

depression. What the above examples demonstrate is the importance of ascertaining, from the client's perspective, what is important to them and therefore helpful for them, and to continue to reassess this throughout treatment sessions, thus individualizing their treatment programme.

The majority of the participants expressed the importance and helpfulness of caring for and being responsible for others. For some, the importance of this was noted in their reasons for participating in the DIS. Others explicitly described how helpful it was for them to have the responsibility of caring for others. Reasons included having less time to be self-focused on feeling depressed.

Half of the participants found the regular filling out of questionnaires to be helpful. For some, it brought awareness to a conscious level and offered understanding. For others, seeing an improvement on the graph was helpful. These findings reiterate the usefulness of using psychometric measures throughout therapy. Furthermore, again, the sense of hope and recovery was reinforced when seeing the improvement on paper.

A few participants lacked understanding of mental illness including depression and, for one, addiction, which likely hindered recovery. Psychoeducation and understanding were reiterated as being helpful and important for many of the participants. According to these participants, this should not be done by way of advice, but in a collaborative way, as those who talked about being offered advice found it unhelpful.

The majority of participants displayed some level of insight into their depression, what was likely maintaining their depressive state, and what would be helpful in assisting their recovery. It is important for clinicians to garner this information and expand on it designed to meet individual requirements, thus enhancing the psychoeducation process.

A number of factors were perceived as being most helpful for participants in the current study. These include mutual respect, honesty, having clear boundaries, empathy, being accepted, support, and, again, the instillation of hope, all demonstrating the utmost importance of developing a sound therapeutic alliance.

Final Statement

Depression is complex and specific to individual experience, regardless of cause and effect commonalities. Studies such as this highlight the importance of treating depression from each individual's perspective, focusing on how they describe their experience rather than attempting to fit everyone into the one model such as the medical model. Results indicate that the medical model for depression and the subsequent use of anti-depressants is not considered useful by the majority of participants owing to unacceptable side effects and inappropriate prescribing. The current study indicates that a social/contextual model of depression might be more appropriate and further such studies are required to replicate and expand on the current findings in order to develop an effective model. Regardless of the chosen model for treatment, individual experience cannot be dismissed in assessment and treatment planning for those presenting with depression.

Stress and anxiety are beyond being common factors associated with depression for this group of participants, and results indicate that they are seen as clearly causal and maintaining factors for depressive symptoms. Implications are twofold: anxiety is likely under-represented and under-reported in clinical presentations and in research, as it is accepted as depression when depressive symptoms inevitably develop in adults; and treatment directed towards anxiety rather than depression will likely see a reduction in depressive symptoms. Furthermore, psychoeducation and anxiety-focused therapy within treatment for depression would likely help maintain lower rates of depressive symptoms and lessen the chance of relapse. Helping to reduce levels of stress, and education about the detrimental effects of avoidant coping used by all of the participants would be beneficial in decreasing symptoms of depression and maintaining such reductions.

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Appendix A

MASSEY UNIVERSITY PSYCHOLOGY CLINIC

I _____, understand that at no time will I be receiving treatment of any kind at the Massey University Psychology clinic.

I understand that the reason for me being at the Massey University clinic is for research purposes only and that during the research period I will continue receiving treatment and assistance from my usual health care provider.

I have had this explained to me by the researcher and understand fully my association with the Massey University Psychology Clinic.

Signed by research participant: _____ / / 2000

Signed by researcher: _____ / / 2000

Appendix B

Name
Address
Address
City

DATE

Dear

Dietary Intervention Study – Follow-Up Appointments

As you know, the Dietary Intervention team is about to begin the follow-up of the study you participated in last year. This letter is to confirm your appointment details for the final phase of this research project.

If you do not want to take part in the follow-up, please call me and I will ensure that you are not enrolled in this part of the research.

What is Involved?

All participants will provide one more blood test and take part in a final interview. The interview is expected to take up to an hour and a half, and repeat all of the questionnaires you filled out previously, and some questions about how you have been since then. In addition we will be asking a few more questions and administering one extra short questionnaire. These have arisen from the information provided by study participants which seemed relevant to the history and impact of depression. We will also provide you with information on which of the supplements you took during the 12-week study last year.

On the next page is an appointment slip for your interview and blood test. If you are unable to attend at the set times, please phone 0800 343-827 and leave a message telling me any days which aren't suitable. I will call you back as soon as possible with a new appointment.

There is also a coloured slip for the blood test, to be taken at Medlab on Victoria Avenue. Please hand the coloured slip to the Medlab receptionist. It is important that you do not eat following dinner the night before the test is taken (water only).

I look forward to meeting you soon.

Yours Sincerely

Researcher

Appendix C

Follow-up Interview

Begin by following up materials on the attachment questionnaires.

How would they describe their relationship with their father?

When growing up

Now

Pursue questions if conflicted/distant or abusive relationship with either parent

Target any other significant developmental crises

Relationship – siblings

Close/distant/conflicted – any abuse issues, physical or sexual

Earliest recollection

First day of school

Follow up on any other early significant life events from the developmental section of the PHQ then move into...

What aspects of participation in the study did you find helpful?

Were there any things your interviewer said or did which stood out for you as particularly helpful?

You remembered and applied in your life?

Give you ideas which helped you begin to make changes in your life?

If you have made some changes in the past year (lifestyle)

Describe them

How have you found them helpful?

Any changes you began to make during the study which you have continued on with

E.g. eating habits

Exercise

Taking up new activities

Increasing social contacts

Different ways of interacting with people or your health professional

How are things different for you now than they were before you began the study?

How are things different for you now than they were while you were participating in the study?

How would you like things to be different for you in the next five years?

What do you think would be helpful to assist you to achieve these, knowing what you know?

What advice would you give to a friend who was/is affected by depression?

Have you noticed any differences in the way you think about life on a day by day basis?

Are there any things you would have liked to say to me that we have not had time to touch on?

Appendix D

Personal History Questionnaire – Final Phase

Name:

Age:

ID:

The purpose of this questionnaire is to obtain a comprehensive picture of your background. It will also be useful information for research that will help us continue to improve our understanding of depression. Records are strictly confidential.

NO PERSON OUTSIDE OF THE RELEVANT RESEARCH STAFF IS
PERMITTED TO SEE YOUR INFORMATION WITHOUT YOUR
PERMISSION

If you do not want to answer any question, just put an “X” in the space. If additional space is needed for responding, use the other side of the sheet, and indicate the number of the question being answered.

Sequential History:

21. What was your earliest childhood recollection?
22. Describe the atmosphere in your home while growing up.
23. Describe the atmosphere at school while growing up.

Please describe your most significant experiences during the following periods of your life. (If you need more room, just cross out the headings and write in your own).

24. 0-5 years
25. 6-10 years
26. 11-15 years
27. 16-20 years
28. 21-25 years
29. 26-30 years
30. 31-35 years
31. 36-40 years
32. 41-45 years
33. 46-50 years
34. 51-55 years
35. 56-60 years
36. 61-65 years
37. 66 years and over

Appendix E

Reflecting on the Research Study

Thinking back to your time in the Dietary Intervention Study, what was the most helpful aspect for you?

- Taking the supplement
- The opportunity to tell your story
- The support of the researcher over 12 weeks
- Knowing you might be able to help others
- Being part of a research programme
- A combination of these things
- Other (please specify)_____

- Being in the Dietary Intervention Study was not helpful to me in any way

Are there any other comments you would like to make?

Appendix F

**Psychology
for a
Sustainable
Future**

A hinengaro mā tōkana ā mua

**New Zealand
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Te Rōpū Mātai Hinengaro o Aotearoa

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**17-20 July 2010
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10.30am

A qualitative exploration of adults' perceptions of the causes of their depression

*Hilary Bradley, Cheryl Woolley and Dave Clarke,
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The present study examined perceptions of 13 previously clinically depressed adults of the impact of stress and anxiety grounded in their actual lived experiences. Eight men and five women took part in exploratory interviews which were analysed using thematic analysis. Four sub-themes were identified as most common across participants: Stress as the core and trigger of depression; avoidance perpetuating anxiety and depressive symptoms; loss and adjustment as common stressors among these participants; and being bullied at school as a common factor. Findings of this study suggest that perceived stress and factors associated with it are correlated with the onset of clinical depression for New Zealanders. Results highlight the need for further research regarding avoidance as a coping strategy in depressed adults. Clinically, it poses the question of whether treatment should be depression-based or anxiety-based. Furthermore, for the majority of these participants treating depression without factoring in family or environmental influences is likely to result in relapse.

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