

Copyright is owned by the Author of the thesis. Permission is given for a copy to be downloaded by an individual for the purpose of research and private study only. The thesis may not be reproduced elsewhere without the permission of the Author.

CONTEXT MATTERS: WOMEN'S EXPERIENCES
OF DEPRESSION AND OF SEEKING
PROFESSIONAL HELP.

A thesis presented in partial fulfilment of the
requirements for the degree of
Master of Arts in Psychology
at Massey University, Albany,
New Zealand.

Jodie Anne Batten

2012

Abstract

Most existing research on women and depression takes a realist approach that effectively silences the voices of women and limits our understandings of depression. By engaging with the stories of seven women, recruited from a provincial New Zealand area, this research privileges women's voices. Taking a discourse analytic approach, this research explores how women construct their experiences of depression and of seeking professional help. I take a micro discursive approach in identifying how the women utilise various discursive resources in constructing their accounts of both depression and of seeking professional help. In order to locate these discursive resources within the broader socio-cultural environment, I employ a macro discursive approach drawing on Foucauldian discourse analysis and Davies and Harré's Positioning Theory. Participant's accounts of their depressive experiences change over the course of their journeys. I explore how the women's accounts shift from a contextualised explanatory framework that locates their experiences of depression within the gendered context of their lives, to a medicalised explanatory framework as they enter the professional help arena. This research offers insights into how dominant discursive construction of the 'good' woman/mother dovetail with a biomedical explanation of depression and prevailing discursive constructions around anti-depressant medications. Working together, these discourses effectively silence women's voices, both pathologising and decontextualising women's depressive experiences. Furthermore, I suggest that these dominant discursive resources and practices offer limited ways for women to make sense of their experiences in meaningful and empowering ways. A need for new understandings about women and depression is called for - one grounded in the material-discursive realities of women's gendered lives.

Acknowledgements

First and foremost, I want to thank the women that gave their time and knowledge to assist me in this research. Of course, I could not have done this without you - my heartfelt, humble thanks for sharing your stories with me. I hope that I have managed to represent your stories and achieved what you hoped.

To Professor Kerry Chamberlain – thank you so much for your time, wisdom, support, and encouragement. Thanks for Monday morning phone calls to keep me on track and remind me there was someone else out there. For a long distance student your support has been invaluable.

Thank you to the North Shore Women's Graduate Institute for your financial support and for your encouragement. It was invaluable and inspiring.

To Dr. Tresna Hunt – what can I say – thanks for being my ear, and my friend. You make it all so much easier.

Thank you to my amazing family – to Jason, who made it possible on so many levels for me to do this work and complete my degree. To my beautiful daughters, Isla and Keira - you are amazing and I love that you have been supportive even when you really wanted me to stop writing and play. And, thank you to my parents for having faith and being there when I needed you.

Table of Contents

ABSTRACT	II
ACKNOWLEDGEMENTS	III
TABLE OF CONTENTS.....	IV
CHAPTER ONE: INTRODUCTION.....	1
WHY FOCUS ON WOMEN?	2
THE RISE OF THE BIOMEDICAL MODEL OF DEPRESSION	3
AN ALTERNATIVE VIEW	5
LOCATING THE CURRENT STUDY	8
THE RESEARCH FOCUS.....	11
CHAPTER 2: METHOD.....	12
DISCOURSE AND SUBJECTIVITY	12
RECRUITMENT	12
PARTICIPANTS	13
INTERVIEWS	14
ETHICAL CONSIDERATIONS	15
ANALYTIC PROCESS.....	16
PRESENTATION OF THE FINDINGS	18
CHAPTER 3: FINDINGS AND DISCUSSION	19
BECOMING DEPRESSED.....	19
<i>A gendered phenomenon.....</i>	<i>22</i>

<i>A feedback loop</i>	26
<i>Wearing the mask</i>	26
CHAPTER 4: FINDINGS AND DISCUSSION	29
ENTERING THE PROFESSIONAL HELP ARENA	29
<i>Professional help - receiving a diagnosis</i>	30
<i>Medicalised understandings</i>	33
<i>Taking up a diagnosis of depression</i>	35
<i>I have a diagnosis</i>	39
<i>A new way of talking</i>	41
CHAPTER 5: FINDINGS AND DISCUSSION	44
THE AFTERMATH.....	44
<i>Section 1: Medicated living</i>	46
Not just a prescription: the performance of prescribing	47
A safe and effective option	49
Constructions of side effects.....	51
Efficacy talk	53
Problems with withdrawal	54
<i>Section 2: Living with complexity: Continuing invisibilities</i>	56
Difficult decisions.....	58
Cautious attempts, the problem with language	60
The trouble with symptoms.....	62
Sadness entitlements	65

Points of resistance and power dynamics.....	66
Circular logic	68
A lack of alternative discursive resources	69
Remaining vigilant	70
CHAPTER 6: CONCLUSIONS	72
REFERENCES	76
APPENDICES	85
APENDIX 1: INFORMATION SHEET	85
APPENDIX 2 CONSENT FORM.	88

Chapter One: Introduction

“...depression is the major scourge of humankind”

(Kramer, 2005: 153)

The aim of this research is to explore women's experiences of depression and seeking professional help. When I first made the decision to explore these aspects of depression, people asked, “Why would you look at depression, surely that topic has been done to death?” There is certainly truth in the idea that depression is a topic that has been extensively theorized and researched, and yet, in spite of this significant body of research, there exists no clear consensus about the etiological underpinnings of depression, or the suitability and efficacy of various treatment models. There is continued debate regarding how best to address depression at an individual and societal level. Depression quite clearly is a highly contested disorder.

The World Health Organisation (WHO) Global Burden of Disease (GBD), 2004 update cites unipolar depression as one of the foremost contributors to disease burden around the world (Mathers, Fat, Organization, & Boerma, 2008). In 2004, unipolar depression was cited as the third leading cause of disease burden worldwide and had the dubious honour of being ranked first in middle-to high-income countries. New Zealand statistics for overall burden of disease from unipolar depression are consistent with international prevalence rates with NZ ranking second in a study of ten high-income countries (Bromet et al., 2011). WHO predicts that by the year 2030, unipolar depression will be the leading cause of disability worldwide.

A further finding from the GBD epidemiological studies that has generated significant concern centres on the gap between the numbers of people experiencing depressive disorders and those receiving treatment. It is estimated that depressive disorders affect 121 million people worldwide with only a small minority of these people seeking or receiving even the most basic care (WHO, 2001). This gap, termed the “treatment gap”, is a primary focus for newly prioritised intervention efforts aimed at addressing the ‘epidemic’ of depression currently facing individuals and societies worldwide.

In the face of such alarming statistics, it would appear, despite the already extensive amount of research on depression revealed by any search of scientific publications, depression is indeed a topic that warrants our attention.

Why Focus on Women?

Epidemiological researchers consistently cite women as over-represented in worldwide depression statistics. WHO cites depression as the leading cause of disease burden for women aged 15-44 worldwide (Mathers, et al., 2008). Furthermore, estimates of lifetime prevalence for depression consistently indicate that women outnumber men at a ratio of 2:1 (Bromet et al., 2011) although others have put this figure higher suggesting ratios of up to 4:1 (Ussher, 2010). Available data for prevalence rates of depression for New Zealand women indicate that these gendered patterns are similarly applicable (Wells, Oakley Browne, Scott, McGee, Baxter, and Kokaua, 2006).

While WHO (2001) epidemiological studies highlight the existence of a 'treatment gap', of those people who do seek treatment, the majority of these will be women. While the processes involved in help-seeking behaviours are poorly understood (Schomerus & Angermeyer, 2008), it is widely accepted that women are more likely to seek help for emotional distress, more likely to receive a diagnosis of depression, and more likely to be treated with anti-depressant medication (Currie, 2005; LaFrance, 2009; Stoppard, 2000; Ussher, 2010). Estimates suggest that women receive two out of every three psychotropic medication prescriptions (Horwitz & Wakefield, 2007). Although New Zealand data is somewhat limited on the use of anti-depressant medication, a 2011 article in a popular monthly magazine *North and South* suggested that anti-depressant medication prescribing rates are at record levels with 1.2 million prescriptions issued in 2010 alone. Women are estimated to take anti-depressant medications at twice the rate of men and in some New Zealand areas almost 1 in 7 people are using anti-depressant medications. According to these statistics, a significant number of women are being diagnosed with depression and treated with medications. This modern phenomenon - depression as a mental illness with a biochemical base - is one that has become highly medicalised, not to mention pharmaceuticalised, and popularised.

The World Health Organisation predicts a significant rise in the prevalence of depression by 2030. If current gendered rates continue unabated, and there is little reason to assume otherwise, women will continue to figure disproportionately in these figures. That is, to put it simply, a lot of women who are likely to experience depression and be treated with anti-depressant medication over the next two decades. There is clearly widespread agreement that depression is a condition that affects women worldwide in alarming numbers. Yet despite WHO's statement that, "mental disorders can now be diagnosed as reliably and accurately as most of the physical disorders" (WHO, 2001, p.22) as Janet Stoppard (2000) points out, it appears that what we know about women and depression is remarkably little.

This raises an obvious question - what is missing from current understandings on depression and women? Perhaps the answer lies in the focus of research and the nature of our enquiries.

The Rise of the Biomedical Model of Depression

Mainstream research into depression has taken a predominantly realist or positivist approach. From within this framework it is assumed that facts about the world can be empirically ascertained through observation and rational deduction – that we can attain objective knowledge (Yardley, (1997) and that this will be untainted by the values, judgements or perceptions of the observer or researcher. Furthermore, this framework assumes it is not only possible, but also desirable to obtain or discover these ‘facts’ independent of the socio-cultural context. From this realist position, subjective phenomena are confounding variables that detract from the true nature of the entity in question.

From within this framework research on depression seeks to identify and establish causal pathways and begins with assumptions of the ‘bounded individual’ – best understood separately from the socio-cultural context. Mechanisms involved in the production of distress are best studied in isolation and researched at their most simple level with a view to generalising to a more complex system. Research conducted from this position has attempted to explain the casual pathways involved in the production of depression as arising from biological dysfunction, primarily in neurotransmitter functioning and genetic vulnerability (Currie, 2005; Rose, 2007). While psychosocial factors have not been ruled out of consideration in the development of depressive disorders, as Rose (2007) points out, it is through their action on the neurochemical brain that they are now understood to have their impact (p. 220). Furthermore, in line with this focus on biological systems, it is concluded that women's greater propensity to depression lies somewhere in women's biology and/or particular cognitive, personality or interpersonal style (Hirshbein, 2006). For research purposes, gender is treated as a characteristic of the individual - either male or female. Treatment is targeted at the level of the individual, either through the use of psychotropic medication or a combination of medication and therapy, most commonly, cognitive behavioural therapy (CBT) (Stoppard, 2000; WHO, 2001).

Feminist and postmodern scholars highlight several problematic assumptions within mainstream theorising and research on depression in psychology (Caplan & Cosgrove, 2004; LaFrance, 2009; Stoppard, 2000; Ussher, 2010; Yardley, 1997). While depression, particularly depression in women, has been conceptualised in various ways, a common thread in these mainstream

formulations is the ongoing focus on the individual as the site of pathology. Thus, while offering potential for a broader theoretical framework for understanding depression, psychosocial formulations are criticised for the continued conceptualisation of ‘depression’ as a discrete and real entity, one that exists independent of language, culture and perception and is located within an individual sufferer (Marecek, 2006; Metzl & Angel, 2004; Pilgrim & Bentall, 1999; Stoppard, 2000; Ussher, 2010; Yardley, 1996).

In addition to this medicalised conceptualisation of depression with its focus on the individual, social constructionist scholars also highlight problems inherent in such models for their conceptualisation of the biological, social, and psychological domains as distinct and separate from each other (LaFrance, 2009; Stoppard, 2000; Ussher, 2010; Yardley, 1996). Existing integrative biopsychosocial and diathesis-stress models for understanding depression and informing treatment strategies are rooted in epistemological assumptions that ‘reify’ limiting dichotomies of body/mind, objectivity/subjectivity, and individual/society (LaFrance, 2009; Yardley, 1997) with the former of each privileged over the latter. These dichotomous conditions not only support they are expressed in the narrow conceptualisation of gender, subjectivity, and the social context in research and thus ultimately in treatment (Cosgrove, 2000; Galasinski, 2008; LaFrance, 2009; Maracek, 2006; Stoppard, 2000). In research based on positivist epistemology, the uncritical acceptance of sex as a subject variable, a dichotomous and stable trait, effectively works to exclude phenomena such as the gendered division of labour and symbolic aspects of gender from theorizing about depression (Stoppard, 2000). In addition, the aim of prediction and causal explanation inherent in these models is said to result in oversimplified, partial understandings (Maracek, 2006). Attempts to assert the dominance of one domain over another in explanations and treatment of depression fails to recognise the continuous and multi-layered reciprocity between all domains of experience (Yardley, 1996).

Yet, despite these concerns, the biomedical model of depression has gained an increasingly high profile in public discourse over the last three decades and currently dominates public discourse (Clarke & Gawley, 2009; Galasinski, 2008; Gardner, 2003; LaFrance, 2009; Lewis, 2006; Rose, 2007). The inclusion of diagnostic criteria for depression in the American Psychiatric Association’s *Diagnostic and Statistical Manual for Mental Disorders* DSM-III (1980) and the biomedical proclivities it rested upon was a pivotal point in the shift toward the construction of depression as a naturally occurring and discrete entity. This new conceptualisation firmly shifted research on depression into a scientific framework whose fundamental premises about the world shaped the type of research that would follow. A biomedical model of depression posits that depression is caused by a chemical imbalance in the brain, and most commonly cites

decreased levels of the neurotransmitter serotonin as the primary problem. From this viewpoint, depression is a mental illness with a biological base best treated with anti-depressant medication. This is clearly reflected in WHO (2001) guidelines that highlight the importance of making psychotropic drugs available to all, and states medication is the first line of treatment when dealing with depressive disorders, either alone, or in combination with evidence-based psychological therapy (WHO, 2001).

An Alternative View

Any reading of popular media coverage of depression, or a search of mainstream academic and scientific publications certainly suggests the dominance of the biomedical model of depression is a *'fait accompli'* – a product of accumulated and ever-sophisticated scientific advances in medicine. Despite this apparent consensus, an alternative is viewpoint offered by social constructionist writers. From this viewpoint, all knowledge prevailing in a culture at a particular point in time is constantly negotiated through social interaction – language, or discourse being the primary source of its construction (Burr, 2003). Knowledge production is therefore always culturally and historically contingent (Burr, 2003; Kirmayer, 2006) and is intimately bound up with power – the power of any regime to promote its particular version of reality (Foucault, 1973). Thus, from this viewpoint, the biomedical model of depression in Western society dominates not because of advances in medicine, but because of the economic, political, and institutional power of science and medicine to construct its particular version of reality (Burr, 2003). Terms such as depression, mental illness, abnormality, and normality do not bear any correspondence to 'real' or discrete entities – rather they are social constructs, invariably dependent on the values and judgement of those doing the defining (Caplan & Cosgrove, 2004). The elevation of such constructs to a supposed 'truth' or common-sense status is dependent on a group's social and political or economic power to promote and maintain this version of events. Furthermore, any particular view or knowledge of events brings with it the possibility of social practices – enabling certain ways of acting while at the same time marginalising others (Burr, 2003) - thus, Foucault's (1973) claim that discourse, knowledge, and power are intimately connected.

From this position, the currently prevailing constructions of depression, particularly constructions of women who are depressed, are viewed as problematic, functioning as an effective means of pathologising and decontextualising women's experiences of intense sadness. The concerns/critiques of the biomedical model of depression are twofold. The first set of

concerns focuses on the assumptions and inherent biases involved in the development of the current diagnostic classification system for identifying depressive disorders – the American Psychiatric Association’s *Diagnostic and Statistical Manual for Mental Disorders (DSM)*. While not all scholars decry the use and potential benefits of such classification systems, this viewpoint does call for a critical stance, and emphasises the need to examine the underlying assumptions and power structures embedded within such systems. Taking a variety of starting points, these critiques include examinations of the particular power structures that serve to promote and maintain this version of reality. Some of these critiques emphasise the need for an historical perspective, highlighting the political and scientific context that surrounded the development of the DSM-111 (Greenberg, 2010; Kirk & Kutchins, 1992) and the resultant adoption of a scientific rhetoric and a philosophy of empiricism. Other scholars, while clearly identifying power structures, focus more specifically on the ‘bad’ science involved in the decision to move away from etiological considerations in identifying depressive disorders to symptom-based definitional criteria utilised in the DSM-111. This decontextualised approach is posited to have effectively removed the distinction between endogenous versus reactive depression, and as Horwitz and Wakefield (2007) state, collapsed the distinction between sadness/grief and Major Depressive Disorder (MDD). Others highlight the interplay between the development of a specific diagnostic category of depression – DSM-111 - and the introduction of medications in psychiatry in the 1950’s and 1960’s (Healy, 1997; Rose, 2007). A particular focus of such critiques is the circular reasoning involved in the development of specific diagnostic criteria for depression *based* on responses to medications that appeared to help individuals thought to be depressed – these individuals then being diagnosed with depression (Gardner, 2003) . This circular reasoning, alongside the political and scientific context that fuelled a perceived need to move psychiatry onto a scientific footing, opened the way to a new approach to theorizing about depression - as a distinct disorder with a biological base.

Other critiques highlight the cultural and gender biases involved in these processes (Hirshbein, 2006; Kirmayer, 2005). Kirmayer critiques the overriding assumptions underlying mainstream theorising on depression – depression as a trans-historical and trans-cultural phenomenon. Hirshbein points to the often hidden gendered assumptions in depression research. She points to the predominance of women in the studies that aimed to develop symptom-based criteria for depression to be included in the DSM-111. Furthermore, she highlights the predominance of women in clinical trials of medications for depression around the same time. Assumptions about women's greater propensity to depression, and assumptions about women's biology as the likely cause, she posits, arose directly out of an uncritical acceptance of these studies on women

as being studies on depression itself. Such assumptions have led to an intertwining of the biology of depression and women's biology that dominates depression research today (Hirshbein, 2006).

A significant number of scholars have explored the relationship between pharmaceutical companies and the promotion of depression as a biomedical illness in scientific and popular media (Clarke & Gawley, 2009). Many of these highlight the role of pharmaceutical companies in expanding medication markets through processes that some have termed 'disease mongering' (Currie, 2005; Double, 2002; Medawar and Hardon, 2004; Moynihan and Henry, 2002). Several scholars have explored the promotion of depression as a biochemical illness through a variety of channels including direct-to-consumer advertising (Currie, 2005) and government depression literature (Gattuso, Fullagar, & Young, 2005). Many critiques specifically highlight the discursive construction of women's unhappiness as depression. Metzl and Angel (2004) explore how Selective Serotonin Reuptake Inhibitors (SSRI) anti-depressants have played a contributing role in expanding categories of women's mental illness in relation to categories of 'normal' behaviour. They concluded there had been a clear shift to positioning women's normal reactions to life events such as marriage, motherhood, menstruation, and menopause as depressive illness treatable with anti-depressant medications. Other scholars have explored discursive constructions of women's unhappiness as depressive illness in popular women's magazines (Gattuso et al., 2005) and in a range of mass-circulated literature (Blum & Stracuzzi, 2004). Through a variety of mediums, particularly SSRI advertisements, emotional experiences such as sadness, crying and never feeling happy, are increasingly positioned as depressive illness (Ussher, 2010).

These critiques highlight the complexity of the relationship between the development of the DSM-111, pharmaceutical companies, and the development of a biochemical model of depression. Such critiques are critically important for women who experience depression. The current DSM classification system is the basis for the majority of research conducted to date on depression and women (Caplan & Cosgrove, 2004; Hirshbein, 2006; Mirowsky & Ross, 1989). As Horwitz and Wakefield (2007) state, "The fact that these symptom-based definitions are the foundation of the entire mental health research and treatment enterprise makes their validity critically important" (p7).

The second, and related set of concerns, primarily focus on the implications for women when depression is conceptualised in this way. The story about women and depression, told through the biomedical model, has real and profound implications for women experiencing depressive symptoms. The way depression is constructed - in this case as a disorder residing in the

individual - whether it is from psychological or biochemical dysfunction - positions the individual in certain ways, has implications for the actions that should be taken, and is implicitly bound up with the construction and negotiation of subjectivity. As Burr (2003) points out, individuals draw on discourses circulating in society to construct different versions of reality. As individuals, we can draw on different discourses at the same time, and thus we can speak ourselves into different ways of being. However, this is only possible within the parameters of the discursive resources, or sets of meanings available within a given cultural context (Burr, 2003, Parker, 1992). Additionally, as Willig (1999) says, “discourses contain a range of subject positions which in turn facilitate and/or constrain certain experiences or practices” (p. 43). Therefore, it is possible for individuals to position themselves *within* discourse and also for individuals to be positioned *by* discourse (Davies & Harré, 1990). The discourses available to an individual therefore shape the ways in which they can understand and experience the world (Willig, 2000). To this end, much of the research within a discursive framework has focused on the medicalisation of sadness and the positioning of women as mentally or medically ill (Riessman, 1992; Ussher, 2010).

It is from within this discursive framework that a growing body of literature offers new ways of looking at women's depressive experiences. One that challenges these essentialist notions of the individual and of gender; one that sees women's depressive experiences as embedded within the landscape of women's lives; and one that recognises the social, discursive, and symbolic aspects of experience as critical in understanding how women experience and understand depression. It is from within this broad framework that the current study is positioned.

Locating the Current Study

This study examines the personal stories of women who have experienced depression and made the decision to seek professional help. The importance of grounding this study in the women's personal stories – to hear *their* voices – to acknowledge the value of their stories for offering alternative ways of understanding depression – became increasingly apparent as I explored the available literature. As Stoppard and McMullen (2003) suggests, knowledge about depression is ultimately held by those who experience it and yet, the voices of those who experience depression are effectively silenced by existing models (Karp, 1996).

Studies that have explored the personal accounts of individuals who experience depression have consistently highlighted the importance of context in understanding how people make sense of their depressive experiences. Using a variety of qualitative approaches, research that focuses on

women's verbal accounts consistently finds that when women are asked to talk about their experiences of depression they do so by talking about the conditions of their lives (Stoppard & McMullen, 2003). Working within a feminist framework, scholars such as Jack (1991) and Mauthner (1998, 2002) have explored women's experiences of depression. Their work has been instrumental in highlighting central themes about women's nature and women's lives embedded within culturally located discursive resources, as critical in shaping women's subjective experiences of depression (Stoppard, 2000). Jack's (1991) study explores women's depression as rooted in the relational self, whereby women internalise cultural imperatives about what constitutes the 'good' women/wife/mother. In their efforts to live up to these impossible cultural images women internalise anger and learn to 'self-silence' in relationships in order to preserve harmony, security, and intimacy. Jack describes how this silencing of anger is intimately connected to women's experiences of depression. Mauthner (1998) also identifies self-silencing as an important theme in women's accounts of depression following childbirth. Normative prescriptions of the 'good' mother/woman - defined as selfless and self-sacrificing, calm, and capable in the face of motherhood - are intimately tied up with a women's sense of moral worth. Mauthner suggests that the women she spoke with struggled with letting go of these normative prescriptions, holding onto rigid ideas about the 'right' way to mother, even while acknowledging that this was harmful to their well-being. Other scholars working within a social constructionist framework explore how individuals negotiate and construct their experiences of depression, drawing attention to the socially constructed diagnostic category of depression (Lewis, 1995; Nicolson, 1991).

Other researchers operating within a social constructionist framework highlight the importance of attending to both discursive and material aspects of experience in understanding women's depressive experiences (LaFrance, 2009; Stoppard, 2000; Ussher, 2010). Yardley (1996) highlights the utility of adopting a material-discursive approach to exploring illness experiences that shifts beyond Westernised mind-body dichotomies. She points to the multi-layered and continuous reciprocity between all domains of experience – the material and the discursive domains are in constant and reciprocal interaction - insistence of one domain's primacy over another, risks obscuring the intrinsically social *and* embodied aspects of human existence. From this perspective, the embodied and subjective experience of depression are considered to be “grounded in and to immediately feed back into the ‘lived reality’ of the activities and social context that constitute everyday life” (Stoppard, 1998, p. 89). A material-discursive approach allows acknowledgement of the reality of women's pain and suffering, whilst recognising that understandings of these are discursively constructed and inseparable from their social, historical, and political context (LaFrance, 2009). A key assumption of this approach lies in

making explicit the socially constructed nature of concepts such as depression, gender, women's lives, and women's bodies. Furthermore, Stoppard (2000) highlights the importance of acknowledging not only the discursive construction of subjective experience, but also the importance of acknowledging the material body as an organism immersed in culture.

Much of Stoppard's work has focused on Westernised discursive constructions of the 'good' woman and its implications for women's well being. She explores how women's lives are shaped and regulated by discourses of femininity –a set of shared cultural beliefs about what it means to be a 'good' woman. Moreover, discourses of femininity are enacted through practices of femininity, which refers to the activities that constitute women's daily lives. Women's bodies are the primary means through which women engage in these practices and Stoppard (2000) posits that women's depressive experiences are one possible outcome of lives lived at the intersection of these discursive constructions of the 'good' woman and the practices of femininity.

LaFrance (2009) takes a critical realist approach to women's depressive experiences acknowledging both the material and discursive aspects of existence. This perspective acknowledges the existence of the material world - and this includes not only the properties of the physical body, but also the properties and organisation of the physical and social environment (Burr, 2003). At the same time, this perspective views our knowledge of the world as always socially constructed. LaFrance draws on ideas from Willig (1999) and Parker (1992) that highlight how these material structures afford the possibility of certain constructions more readily than they do others. With this in mind, LaFrance takes a discourse analytic approach drawing on both top-down and bottom-up approaches to exploring discursive resources and practices in her research on how women construct their depressive experiences. Her work particularly focuses on how medicalised biochemical constructions of depression position women and their depressive experiences in such a way that the subjective experience of depression is stripped of its social and political context. She suggests that an ongoing adherence to a positivist ontology that rests on assumptions of naturalism and individualism leaves few possibilities for legitimising one's subjective experiences. Furthermore, she explores how the ideological and institutional structures of discourses of femininity and biomedicine work together to both silence and create women's pain (LaFrance, 2009)

The Research Focus

Drawing on findings from these authors that highlight the importance of exploring material and discursive aspects of women's depressive experiences, the present study aims to add to this small but important body of knowledge about women's depression. Despite the consistency of findings from feminist and social constructionist scholars, these ways of understandings women's depressive experiences is absent from mainstream theorising about depression. This study seeks to add to this body of discursive research by exploring the subjective experiences of depression and the seeking of professional help for the women who participated in this study. I aim to explore the relationship between the women's subjective experiences and their discursive worlds; to explore, describe, and critique the discursive world the women inhabit and the implications for possible ways-of-being. In order to do so, I draw on aspects of Foucauldian discourse analysis, and Davis and Harre's positioning theory (Davies & Harré, 1990; Harré & van Lagenhove, 1999; Willig, 2000).

In doing so, I hope to offer some new insights into the processes involved in the women's experiences of depression and their sense-making journeys.

Chapter 2: Method

Discourse and Subjectivity

Before continuing, I wish to make explicit the assumptions on which this study rests. The primary focus of Foucauldian discourse analysis is the role of language in the constitution of social and psychological life. The availability of discursive resources within a particular culture, from a Foucauldian viewpoint, has implications for those who live within it (Willig, 2008). Parker (1994) defines discourses as “sets of statements that construct objects and an array of subject positions” (p. 245). These constructions afford individuals certain ways of seeing-the-world and being-in-the world (Willig, 2008). Given these assumptions, Foucauldian discourse analysis explores the role of discourse in the constitution of subjectivity, selfhood, and power relations (Burr, 2003; Willig, 2000). While much of the work by discourse analysts involves the examination of expert discourse and theorizes possible implications for subjectivity from this work, I have chosen to approach this from a different position. This study is concerned with the subjective experiences of the women involved and as such is grounded in the ‘realities of the women's lives – attention to the material and social aspects of the women's stories remain a focus throughout the analysis. Discourses are grounded in social and material structures, such as institutions and their practices (Willig, 2000) and as Parker (1992) reminds us, therefore we need to “...attend to the conditions which make the meaning of texts possible” (p. 28). I begin with the women's accounts of depression and seeking professional help, identifying the prevalent discursive constructions in the women's stories. In order to offer a contextualised understanding of the women's constructions it is important to move between a micro-focus and a macro-focus in order to define and critique the discursive worlds the women inhabit.

Positioning theory offers a useful conceptual tool for exploring the subject positions afforded the women from within any particular discourse. Subject positions from this viewpoint, “constitute ways- of-being through placing the subject within a network of meanings and social relations which facilitate as well as constrain what can be thought, said, and done by someone so positioned”(Willig, 2000: 557).

Recruitment

Recruitment of participants took place in a provincial centre in the North Island of New Zealand. Given the small number of people required for this study, it was hoped a snowballing effect would be sufficient for recruitment purposes. I initially spoke with two people in my community whom I knew to have had experience with depression and whom I knew would be

comfortable with my speaking to them about this. I invited them to participate and asked that they extend this invitation to anyone they thought might be interested. I also spoke with a small number of people in my community about the research I was undertaking and asked that they pass this invitation to anyone they thought might be interested in participating. Interested parties had a number of options for initiating contact about participating in this study. Anyone that felt comfortable doing so had the option of contacting me directly via e-mail or telephone. If they preferred they could request an Information Sheet (see Appendix 1) from the person who initially spoke with them about the study. A third option of having their name and number passed to me so that I could initiate contact was also available. At all stages of this initial process it was clearly stated that by contacting me or asking for an information sheet, interested persons were not making any commitment to participate.

Seven women requested that I make initial contact with them to speak in more detail about the study – all of these women agreed to participate at this point. On contacting the women, I explained the purpose of the study, and the criteria for participating. I explained that I was interested in hearing their stories of depression and seeking professional help and that I thought it was important to hear women's voices - voices often lost in stories of depression. For the purposes of this study, participants were required to have experience with what *they* identified as depression at some point in the past 2 years and to have sought professional help during this time-period. Professional help may have involved one appointment or several appointments. Given the possibly sensitive nature of the topic in question, and in order to ensure the safety of anyone who decided to volunteer, it was important those women who had continued involvement with professional help services identified as being past any crisis that may have led them to seek help in the first place. In addition, those women who had continued involvement with mental health services were asked to identify a named person they were comfortable speaking with should any issues arise for them. These ethical and safety issues, critical in the recruitment process, formed a significant part of the Massey University Human Ethics Committee proposal and considerations -see below.

Following this initial telephone contact, all of the women volunteered their time. Interview times were set and in the meantime, I arranged to send an Information Sheet to the women and asked them to call me if they had any further questions or if they changed their minds.

Participants

Seven women volunteered to participate in the study. They ranged in age from 33-43 years. All of the women were married, although one woman was recently separated. Although this study

did not set out to specifically recruit mothers of young children, those women that volunteered their time and knowledge were all mothers to pre-school and primary school aged children. Five of the women had two children, one woman had three children, and one woman had four children. Given the method of recruitment, the likelihood of this occurring is not surprising - at the time of undertaking this research, I had one pre-school and one primary school aged child. A significant portion of my time was spent involved in early-childhood settings.

The women's economic, social, and personal circumstances varied. Only one of the women was working outside the home at the time their stories of depression took place. All of the women identified as New Zealand European.

Interviews

The women requested interviews be conducted in their own homes and suitable times were arranged that were likely to bring a minimum of interruption. Perhaps the most important part of the interview process was establishing rapport before moving onto exploring the topic in question. The feedback from each of the women strongly suggests this was successful and facilitated a safe and meaningful experience for all concerned. One woman told me that she had recommended being involved in this research to a friend because it had been a powerful and empowering experience for her. Six of the seven women told me this had been their first opportunity to tell their story freely and without time limits – and as such, they found it a thought-provoking and positive experience.

Prior to starting the interviews, we discussed my role as researcher and student; the women were encouraged to ask any questions. We addressed issues of confidentiality at this point - the likelihood of contact between a number of the participants and me through our mutual involvement in early childhood and school services was an important area of discussion. Given the participants were sharing often painful and private experiences with me it was important to talk about how this might be for them following the interviews and at any later date.

Interviews lasted on average between 1½ - 2½ hours. I conducted the interviews in a relatively informal and supportive manner. I began the interviews by asking the women to choose where they would like to start - where it felt comfortable and made sense for them to do so. The women were free to choose how they addressed these issues and to bring forward any topics they felt were relevant to their stories. I specifically wanted to ensure that the women had the opportunity to raise anything they considered important rather than impose any pre-conceived notions of what I thought was important. I used a small number of open-ended questions intended to ensure coverage of three major areas of enquiry - the women's experiences of

depression; their decision to seek help and their experiences of seeking professional help; and how they made sense of these experiences. Additionally, I sought clarification where needed in hopes of avoiding making assumptions on my part about how the women might have made sense of, or felt about, various aspects of their experiences.

All interviews were audio-recorded. I personally transcribed each interview. My intention during the transcribing process was to produce a transcript that was representative of the women's original wording. Some aspects of speech, other than wording, have been included only where they add to 'hearing' the voices of the women. Throughout the analysis, I have used pseudonyms for the women's names and have used the initials JB for myself. Italics have been used to present the speech of the women and the interviewer. Any clarifying information has been provided in written form where needed at the end of the relevant excerpt.

I have used **bold** to indicate speech emphasis.

Where the women took long pauses I have noted this in words.

I have used three periods ... in a row to show that some speech has been left out of an excerpt. I have used square brackets [] to indicate that information has been omitted for confidentiality purposes.

Ethical Considerations

I sought permission to undertake this research through the Massey University Human Ethics Committee: Northern (MUHECN). Details of the ethical considerations relevant to this study were outlined and addressed in the submitted proposal. The primary focus of such considerations was the safety and confidentiality of those involved. Given the sensitive nature of the topic in question, the potential for possible distress during and after interviews was a primary concern. My previous experience working with vulnerable groups and an ongoing commitment to reflective practice provided me with the experience to conduct interviews in an ethical manner that reflects an awareness of power and vulnerability issues. These issues were further addressed with each participant, (see Recruitment, and Participant section) and detailed in the Information Sheet (Appendix 1). Information pertaining to confidentiality, including treatment of audiotapes and transcripts, was included in the Information Sheet. The Consent forms (Appendix 2) specifically related back to the Information Sheet and provided the option for feedback if the women choose. Ethical permission was approved without additions or changes (No: MUHECN 10/010).

Analytic Process

Analysis began with repeated listening to the audio tapes. The aim was to create a sense of felt-context, to familiarise myself with the stories as they were narrated. This heard context, removed when I began working with the transcribed materials, proved valuable as I immersed myself in repeated and thorough readings of each transcript, taking note of the overall structure of each story. It was quickly clear that the women narrated stories that were remarkably similar in structure and it this structure that informs the presentation of the findings in Chapters 3-5. (I return to this shortly).

Repeated readings of the narratives provided a framework for exploring the discursive resources used in the construction of each woman's story of depression. I began by examining all references to various aspects of distress, sadness, and depression and then located each of these within its surrounding context. This enabled me to identify the different ways the women constructed depression or associated experiences as they moved through an unfolding story of becoming depressed and seeking professional help. This was important given the women changed the way they constructed their depressive experiences as they moved through their narratives.

I identified prevalent discursive construction of distress throughout each narrative, and then identified prevalent discourses surrounding these constructions. In doing so, I was constantly contextualising what the women were telling me. For example, during the reconstruction of the women's experiences of 'becoming depressed', the women spoke of their inability to cope as arising from an individual flaw. In order to explore how they had come to this conclusion it was important to look at the discourses surrounding this notion and to examine how these might support this idea. Equally important was attention to what may be missing from the surrounding conditions that constrained the women arriving at a different conclusion. I was conscious that in examining a particular section of text away from the surrounding text, there is a risk of losing the context of the construction in question. It is possible to lose some of the context for exploring, "why this way?" Having identified the various ways the women constructed distress and depression, and the meaning these experiences held for them, I examined how these changed over the course of their story. In the early part of the narratives the women drew on contextual explanations for their distress, as they moved through their stories, these explanations shifted to internalised constructions where the women saw themselves as 'bad' mothers - further into their stories these explanations shifted to accommodate biomedical explanations.

I then shifted my focus to explore the broader socio-cultural context. I immersed myself in the depression literature. I examined and critiqued various constructions of depression available in society and explored the subject positions that may be available within each of these. I explored existing literature that explored these topics to see which of these, if any, helped to make sense of the data provided by the women. I read and read and read. Some of what I read while certainly interesting and possibly relevant, was not relevant to the data that I was working with, and so I either put this aside or where appropriate, suggested its possible relevance within the discussion. Other readings proved more fruitful and allowed me to build a 'contextual map'. I continually moved between the literature and the data. The questions running through my mind as I did this revolved around issues such as, "how do you construct your story of depression, why have you drawn on this discursive resource and not another, what subject positions does this make available to you, how does this constrain or enable certain actions, thoughts, ways-of-being?" The relationship between discursive resources and practices, the positions they offered, and the women's subjective experience was at the forefront of all these questions.

Throughout this process, when identifying discourses reflected in the women's talk, it was important to take an historical exploration of the discourses that surrounded and supported these primary ones. In doing so, the question becomes more focused on institutional power and practices – "Why is this discourse more readily available than another – what supports this – what broader discourse might this be part of?" Another set of questions I employed as I moved between the literature and the data, focused on, "What constrains the women from taking up positions available within different discourses – what happens when they do?"

As I moved back and forth between the literature and the data, I merged the findings regarding what is happening at the micro level – the women's stories - with the broader stories in the cultural context they inhabit –macro-level. The importance of merging these two together to provide a contextualised account drives the decision to present the findings and discussion together. Through this process of merging, the women's stories made more and more sense, the trajectories they moved along were apparent, and they were located quite clearly within a cultural context that more easily afforded certain ways-of-being and not others. The final analysis offered a way of seeing the unfolding processes, the depression trajectories of the women – whereby, given this particular context, drawing on these particular discourses, offering these subject positions, the relationship between the women's discursive worlds and their subjective experiences of depression became highly visible. While another person may produce an entirely different reading of the women's transcripts, I leave it to the reader to decide if, given the explicit assumptions I have outlined, the following story – The Findings –represents a

plausible, useful, and meaningful account of the depression trajectories of the women who participated in this study.

Presentation of the Findings

The women all began their stories with a contextualised account of the conditions leading up to ‘becoming depressed’ - they spoke of their decision to seek help and their experiences of seeking help – and they spoke of life after diagnosis. Given the clear structure of each of the women's stories, I have presented ‘The Findings’ following these lines: **Chapter 3 -Becoming Depressed**; **Chapter 4 – Entering the Professional Help Arena**; **Chapter 5 – The Aftermath - Section 1 – Medicated Living, Section 2 – Living With Complexity, Continuing Invisibilities.**

Excerpts used throughout the Findings Chapters reflect the speech used in the original narratives and wording has *not* been adjusted to provide ease of reading. I have not included a number of aspects of speech acts such as utterances, inflections, except where this is important for providing information – such as long pauses or the use of notable emphasis. All participants were assigned a pseudonym. I have made every effort to use speech excerpts from all the women in similar quantities.

Chapter 3: Findings and Discussion

Becoming Depressed

When I asked the women if they could tell me about their experiences of depression and how they managed to make sense of what was happening to them, I suggested they started wherever it made sense to them to do so. It was clear the women had no difficulty finding a starting point, a space where *'it'* began - where things started to go wrong. Their experience of depression had not occurred within a vacuum; the stories were located within a time and place, a contextual setting. That the larger part of the women's narratives, was made up of this contextual explanation suggested its importance to the women. Not only did the attention paid to reconstructing this part of the story indicate the importance of context to them, it suggested they felt it was important I understand that in fact there had been a context. They drew on social, relational, and material aspects of their lives to position themselves within the locale where their experiences of depression had occurred, and in doing so told stories that were rich in detail, varied and ultimately complex. While it is not the intention of this analysis to explore in detail the content of each woman's story, I do wish to illustrate this contextual complexity by providing a brief outline of some of the most important social, relational, and material aspects of one woman's life that she brought forward when talking about her experiences of depression.

Kate told of how she had cared for her deeply depressed mother following her parent's divorce. She looked after her mother essentially on her own from age 21 -24, until her mother finally took her own life. She talked of the shame of divorce at that time and how she felt watching her strong, vibrant mother become a shell. She went on to tell of her upcoming marriage, her impending role as stepmother to two children and the unfairness of being cast as the *'other woman'*, the *'evil stepmother'*. She spoke of mixed feelings regarding her changing identity from individual, to wife and stepmother, of the loss of freedom and increased responsibility. She spoke about the exhaustion and anxiety she felt as she managed her own business while also managing a newly formed household. She was uncertain about her fiancé's commitment to this new venture and felt she was putting in far more effort to accommodate his children and their needs. She was angry and tired, and was having difficulty sleeping. And, if that wasn't enough, she talked about the trauma of finding a friend who had successfully suicided. She finished this scene setting by concluding that, *'I guess that's some quite big stuff'*. The content of this story is unique to Kate and as we would expect the content of each woman's narrative is uniquely her own. However, what this summary so clearly illustrates is the level of contextual complexity that makes up the conditions of this woman's life. Her story highlights numerous

elements or strands interacting and feeding back. There is fluidity to how each strand moves and weaves with the other strands; none of them simply existing in isolation; to try to understand them as such leaves one with an incomplete picture.

When we look at the elements highlighted in another woman's story, it is possible to see this contextual complexity illustrated again. When Susan's story began, she had recently stopped working and was at home caring fulltime for her three children. She has one older child and has recently had twins. There has been a significant change in the family's financial situation since she stopped paid work and her day-to-day activities have changed dramatically. She is married but describes her husband as uninvolved in the care of the children. She feels she has no support from him with regard to any issues related to looking after their three children. In fact, she feels he resents her for not being more available to meet his needs. She feels resentful of his demands whilst also feeling guilty if she does not meet them. She says he often treats her in a manner that leaves her feeling frustrated, unattractive, and alone. Their marriage is on rocky ground and they do separate part way through this story. She describes the rising exhaustion she feels as she cares for her children essentially on her own, and the relentless demands of breastfeeding and night feeds. She has little time with twins for doing anything other than looking after them and keeping the house clean and food on the table. She also talks of the high expectations she places on herself to be a good wife and mother and how trying to fulfil these expectations leaves her utterly depleted of energy. At the same time, she feels guilty about all the things she cannot do and all the things she does not do well, including attending to the needs of her eldest child who experiencing problems at school. She talks of the conflict that arises between her mother who offers support and her husband who resents this support; how she feels caught in the middle and eventually finds herself forced to ask her mother to stop coming to their house in order to avoid the conflict this creates with her husband. She tells me how telling her mother -and her only source of practical support -not to visit anymore, leaves her saddened, angry, and alone. Susan talks about her upbringing; she believes this plays a part in her unwillingness to confront her husband. She talks of her father having bi-polar affective disorder and of the daily arguing and yelling she witnessed as she was growing up. An overwhelming desire for peace and quiet was the result; and this avoidance of conflict was instrumental in her choosing to swallow her anger with her husband. She knew there was a cost but still felt compelled to pay this price because at the same time, she felt a great need to protect her children from seeing their parents argue. She talks in some detail about growing up in her family with a parent who is mentally unwell. She also talks at length about a relationship with her mother that is supportive, and at the same time, a source of shame in relation to her perception of herself as weak for not coping as well as she thinks she should. Throughout her narrative, an overarching

theme is the exhaustion, the constant and relentless tiredness she experiences and the inability to find space or time to revitalise any reservoirs of energy she may have. Susan tells of reaching a point where she just ran out of energy – she says, “*I just had enough, I couldn’t do it anymore*”.

While we see a story here that is quite different in content from the previous story, what is remarkably similar is the contextual complexity contained within each narrative. The strands do not stand alone. Both women’s stories whilst unique in content are not unique in this complexity; complexity is inherent in all the women’s stories. The women made it clear to me there was a context to their stories and to understand what had happened, I needed to understand the context in which their experiences were located.

The women's stories were, in varying degrees, filled with accounts of trauma and violence, loneliness, childhood bullying, family and relationship troubles, physical health problems and, for some, poverty. The women talked about aspects of their lives they considered may have played a role in the stories of depression, and as one would expect, each of the women highlighted aspects particular to her life, as being more or less important in these experiences. However, it was also clear the stories they told were ones embedded in their lives as women; they were gendered stories. They spoke of aspects of their lives intimately tied up with their identities as mothers, as daughters, and as wives. These stories were filled with the demands the women faced as they managed relationships, provided childcare, ran households, provided care and love for those around them, worried about finances, struggled with health problems, and struggled with lack of sleep and lack of time. Alongside these demands, the women also spoke of isolation, loneliness, frustration, ambivalence, and in the negotiation of such complexity the women spoke of the unceasing demands upon their physical/material bodies; demands that left them depleted, anxious, and exhausted. They described their struggles to manage this complexity, to keep moving forward without complaint or without showing signs of this struggle, and central to all of these aspects of experience, was their ongoing struggle to live up to their notions of what it meant to be a ‘good enough’ mother, daughter, and wife. What is interesting in these reconstructions, is that as much as each of the women brought forward this contextual complexity, their stories hold a powerful tension; context is important, it is within this context their experiences of distress take place, and yet, they do not perceive these contextual conditions as sufficient to legitimise that distress. As we move through their stories, we see the importance of this tension-filled discordant relationship between the contextual complexity of their lives, and their perception that these same conditions are insufficient to account for the level of distress they feel. It is the production of this tension, and the

implications for the women as they find themselves caught at the centre of such tension, which is of interest in the remainder of this chapter.

A gendered phenomenon. When beginning this stage of the analysis around women's accounts of depression, and delving into the vast amount of literature that has been generated by researchers in their attempts to predict and explain depression, I was struck by the comparatively small number of studies that began their analysis from the individuals own account of becoming depressed. Equally striking amongst this small amount of research that does begin with individual accounts, was the consistency of findings that strongly supports the assertion by social constructionist and feminist writers that depression is a gendered phenomenon (Galasinski, 2008; Jack, 1991; LaFrance, 2009; Maracek, 2006; Stoppard, 1998, 2000; Stoppard and McMullen, 2003, Ussher, 1991). This assertion by social constructionist and feminist writers that depression is a gendered phenomenon is not new and presupposes that gender encompasses more than an individual's biological sex assignment. Typically, research into depression has treated gender as a characteristic of the bounded individual where, as Stoppard (2000) describes, the boundaries of the individual start and finish with the surface skin of the physical body and gender is defined as the person's sex assignment, that is, either female or male. However, when gender and the individual are conceptualised and operationalised in this way, fundamental aspects of their experience are excluded from consideration and therefore from our understandings of depression. Stoppard (2000) points out that when aspects of gender such as the division of labour in society are ignored or taken-for-granted, and symbolic aspects of gender within the discursive domain are excluded from consideration in depression research, the socio-political and cultural context of people's lives is rendered invisible (p18). Consistent with this, the women's narratives strongly suggested that it is here, embedded within this socio-cultural arena, and bound up with central elements of symbolic gender such as the widely shared and often implicit assumptions about femininity that their suffering is located. In line with studies that take women as their starting point (LaFrance, 2009; Stoppard, 2000), I suggest that for the women in this study, it is at the intersection of what these social constructionist writers term 'discourses of femininity' and 'practices of femininity' that their suffering is located.

Stoppard (2000) uses the term 'discourses of femininity' to denote "the set of discursive resources that have women as their focus" (p. 209). In Western society, cultural discourses of femininity often portray women as inherently caring, nurturing, emotional, empathetic, self-sacrificing, and other-oriented (Bamberg & Andrews, 2004; Burr, 2003; LaFrance, 2007, 2009; Miller, 2005; Stoppard, 1998, 2000). These discourses operate through the largely unconscious or taken-for-granted assumptions shared by people living within the same socio-cultural context

(Stoppard, 2000) and far from being simply abstract ideas, are intimately connected with institutional and social practices (Burr 2003). As such, they have powerful implications for the way we can and do live our lives. As Burr (2003) says, it is only a short step from these assumptions, to construct women as the most natural carers of children and other family members, and most suited to the tasks of running domestic households, and thus discourses of femininity dovetail with structures and practices in society that support the gendered division of labour.

Embedded within these broader discourses of femininity are powerful imperatives about mothering and family life that position women as responsible for the smooth running of domestic life, regardless of employment outside the home, and as ultimately responsible for the lifelong welfare of their children who require selfless, intensive nurturing (Miller 2005; Stoppard, 2000). The idea of 'good' mothering, and the 'good' woman generated from within these discourses, carry alongside them the possibility of the 'bad' mother, the 'bad' woman. It is perhaps no coincidence, that during the course of her story, each of the women in this study embarked upon, and was immersed within, a story of mothering pre-school children and it is within this locale the women's stories take place. The women's stories in this analysis centre on their day-to-day activities, those regulated and shaped by discourses of femininity - taken-for-granted and often devalued -performed by the finite resources of the material body. It is here at this intersection between discourses and practices of femininity that their stories of depression unfold.

I chose to focus on these two aspects of experience in relation to family life and mothering in large part because of the dominance of their presence throughout the women's narratives, and certainly, because of how they are implicated in the subjective and embodied experience of suffering for these women. In addition, however, I was also struck by the consistency of findings from research that begin with women's accounts showing these elements as important in women's depressive experiences (LaFrance, 2009; Stoppard, 1997, 1998, 2000). Yet these day-to-day aspects of women's lives are largely absent in theorising about depression and women's distress in Western society. It is important to be clear, however, that by looking at these particular aspects of the women's experience I am not suggesting they can, or should be, separated from other aspects of the women's stories. They intertwine with the women's subjective history, and their individual material and discursive worlds. They are however, referred to consistently by the women as critical elements in their story of depression, and have an implicit and interesting relationship with their decisions to, and experience of, seeking help.

At this point I want to return to the idea brought forward earlier about the production of tension arising at the intersection of the women's intensely complex day-to-day lives, and their perception that these conditions are not sufficient to legitimise their distress. When we consider the taken-for-granted nature of these conditions, arising in a socio-cultural context that takes an essentialist view of gender, and thus constructs women as naturally/innately suited to these tasks, it is possible to understand how these conditions are normalised and become invisible as sources of distress in women's lives. However, it is not these conditions alone which are implicated in the production of this tension - a woman's ability to perform gender in this way is inherently reliant on the material body, one that clearly has finite resources and is at risk of depletion and exhaustion (LaFrance, 2009; Stoppard, 1998, 2000). The women speak at length of the toll exacted on their material bodies from the endless task of caring for others (children and adults), running households, completing domestic chores, and engaging in voluntary or paid employment. There are times when these clearly become overwhelming. The relentless demands these practices placed on the material body, and its finite capacity to "*keep on keeping on*" was something the women struggled with on an ongoing basis. Susan describes the fatigue and demoralisation she experienced as she cared for her young twins without the support of her husband, she says, "*You wake up after one and a half hours' sleep and you think; I have to do this all over again, what's the point, what is the point? I ended up walking around and around the house saying what's the point – it's never going to end, and then you look at the clock and it's only half past eight in the morning...It's the tiredness, the tiredness – you are just so stuffed*". Sara talks of the struggles she has caring for her grandmother with Alzheimer's, both her children's difficulties with dyslexia and the struggle to support them whilst running a household with young children, a husband to care for and a part-time job. She says, "*It's exhausting, it so mentally exhausting*". Kelly describes how she felt when woken at regular hours during the night with her young baby and she was exhausted. "*It suddenly dawned on me, he's screaming in the night, fuck this is for life and I am so tired, I just need to sleep and I don't want to be up and he won't shut up and there's nothing I can do and I feel completely and utterly trapped*".

When these taken-for-granted day-to-day practices are interwoven with the idea of the "socially revered 'good' woman" (LaFrance, 2009, p.11) - one who places others needs above her own, is pleasing and self-sacrificing, and is contented in her household and nurturing work - the production of this tension becomes increasingly visible. We can see the interweaving of the material/embodied aspects of experience with the discursive strand of what it means to be a good woman and particularly what it means to be a good mother in the following excerpts. Susan describes the expectations she had of herself, "*you know, to cope with everything, to have*

the tidy children and the clean, tidy house, yeah and be a great parent. I did baking and bloody stupid me, I didn't slow down enough. I just wanted to be the best mother I could be. And wife, that I could be and um try and cope". Other women talk of the guilt they experience at the prospect of saying 'No' to requests for their time, even when they are exhausted and have little time and energy to spare. Angela tells how she engaged in community work as a way to feel she was "*giving something back*" but how instead of making her feel good about herself as it was meant to, it just drained her further and further of energy. Kate talks of the struggle to manage demands at home and work, and her struggle to say 'No' without feeling she is letting people down. She says, "*I don't like to disappoint people so if I am asked to do anything or help someone, it's so easy to give, give, give ...I feel like it makes me a better or more likeable person or something*". She goes on to tell of waking at night panicking at all the things she has to do, how she feels "*ripped off*" that she can't be the "*earth mother*" she wants to be because there is so much else to do. She says, "*There's so much pressure that sometimes I can't breathe*". Repeatedly, the women recounted their attempts to live up to the ideal of being a 'good' woman, one who did not say No to others, who helped out whenever asked to, who put their own needs aside for the sake of others, and who gave everything to attending to the needs of others.

Given the taken-for-granted nature of these conditions interwoven with the discursive strand around the 'good' woman and mother, it is not surprising the women condemned themselves for being unable to perform these practices without sometimes feeling angry or resentful, for sometimes lacking in patience or having mixed feelings, and ultimately for being unable to do them without feeling exhausted. As Rebecca says, "*you keep asking yourself - what is wrong with me, what is wrong with me?*" Several of the women spoke of their distress at the thought that other women were able to manage what they so clearly felt unable to manage. Kelly spoke of her husband's questions about this. She says, "*He would ask me "what's wrong with you, other women don't have all these bloody problems. What's wrong with you, you just need to get on with it?"*" Several of the women spoke about their decision to try harder to work at performing these practices with more and more of the same, in their efforts to achieve some sense that they were indeed good mothers and wives. Invariably this decision resulted in further depletion and demoralisation. Angela describes this, she says, "*I was so busy trying to feel that I was a good friend, a good mother, a good wife. But you're doing all these things and running around everywhere and you aren't putting anything back into the vessel, and it gets emptier and emptier, and then it's empty, and you feel like you're just an empty vessel, that's all you are*".

A feedback loop. Angela's description illustrates the weaving of the material-discursive aspects of her life. It is here at the intersection of these two closely connected threads of experience that the women become engaged in a vicious feedback loop. A loop generated by cultural discourses of femininity and motherhood that render the conditions of their day-to-day lives invisible as sources of distress, and at the same time constructs the identity of the 'good' woman as one who prioritises the care of others and engages in self-sacrifice. The distress and depletion generated at the centre of this struggle is subject to constant self-appraisal. Given the taken-for-granted nature of these conditions, and the belief that these are not sufficient to *legitimise* their distress, the women come to see their distress and perceived inability to live up to normative prescriptions of the good mother/woman as evidence of not coping. Crucially, the women construct this inability to cope as arising from individual and personal failing. They see themselves as personally flawed. The possibility that the conditions of their lives and the demands they face within this socio-cultural setting may be more reasonably held to account, is at best tentatively toyed with, but ultimately rejected. Several women told me that they had no right to be depressed as their lives were good; they did not have abusive husbands, they had good homes, they had no physical injury to show. As Angela said *"People would say what's wrong with her, she has a nice house, two lovely children, a husband who loves her, who the fuck does she think she is?"* And, in this context, the women talk about the realisation that they are indeed 'bad' mothers and failures as woman. They spoke of their ensuing sense of being *"useless"* and *"worthless"*, of feeling *"like the biggest failure"*. Kelly talks about *"slamming"* herself as a mother and a woman when sitting exhausted in the early hours of the morning with her newborn son; she feels grief for her old life and fears her ability to manage when she is so tired. She cannot allow herself these feelings, fuelled by exhaustion and huge changes to her identity, without condemning herself as the worst sort of mother. The suffering arises not only from the limitations of the material body as it strives to perform the daily demands and is inevitably depleted and defeated, but also from their subjective appraisal that constructs their difficulty in doing so as directly related to some flaw within themselves. They conclude they are indeed not a 'good' mother and wife, and so not a 'good' woman. The sense of demoralisation and shame generated at this intersection continues unabated, for as the women say, the motivation to hide this flaw from themselves and others is a powerful one.

Wearing the mask. When women construct their ongoing distress as inability to cope because of a personal flaw, and this speaks directly to their identity as women and mothers, the shame and guilt generated becomes a powerful motivator to hide this distress. This motivation to hide their distress is further enhanced by the women's perception that they should cope with these difficulties alone. As Helen said, *"I should be able to sort this out on my own. Other*

people don't run round asking everyone for help do they? Anyway who wants to hear that you're feeling crap all the time, people want you to be happy, not going on about how crappy you feel". Outram, Murphy and Cockburn (2004), in their study around barriers to accessing professional help for distress, found that the belief that one should cope alone was a major barrier to accessing help. Gattuso et al., (2005) highlight how depression discourses in popular magazines foreground a level of individual responsibility, promoting self-management and self-sufficiency as the dominant strategy for managing distress. Additionally they point out how these discourses can lead to an isolating individualism that leaves women blaming themselves for not managing the complexity of their lives. Some of the women also made reference to the idea that sadness was a socially undesirable emotion – that people did not want to be around sad people and that there was a limited tolerance to any extended periods of sadness. Lutz (1985), (cited in Galasinski, 2008) points to the cultural constructions of emotions and the notion that normality involves positive affect – “a lack of ‘the pursuit of happiness’ is deemed particularly deviant” (p.4).

The women spoke repeatedly of using a ‘mask’ to cover their distress, to enable them to present a “*cheerful face*” that kept hidden/contained the evidence of themselves as ‘not coping’, to avoid others perceiving them as possibly weak, indulgent, or hypochondriacs, and therefore as ‘bad’ mothers and ‘bad’ women. Angela described how keeping up the mask became more and more difficult and led to her withdrawing from social situations. “*I would make excuses not to go out so that I didn't have to interact with other people and pretend to be happy. It was too hard and I didn't want to because it felt false - sometimes I could do it and other times I just didn't have the energy to wear the mask, the energy needed to keep it up*”. Kate made several references to her “*happy, cheery face*”, the face she showed to others because as she said “*this is my job, to be the cheery fixer upperer*”. However, she also spoke of her realisation that this ‘face’ was one that required increasing amounts of energy to keep in place. Susan describes this mask, “*I would put on a front. I would put on whatever I possibly could to think I was OK – I can look after the kids, I'm a good wife, I'm a good mother*”. This internalised construction of their distress and the need to keep this contained led to the women engaging in strategies such as being silent and withdrawing from contact with others. At the same time, the women were trying harder to perform as ‘good’ mothers and women even though these efforts were further depleting already stretched time, energy, and emotional resources. These practices or strategies were unable to keep the women's distress hidden from either themselves or others, and the enactment of the feedback loop interacting with their unique subjective history, material and discursive worlds, continued to generate increasing amounts of distress. This is evident when the women talk about the level of distress they reached before they undertook what they all

described as a particularly unwelcome and difficult decision, the decision to enter the professional help arena.

Chapter 4: Findings and Discussion

Entering the Professional Help Arena

Entering the arena of professional help and receiving a diagnosis was a turning point for the women in this study; a transforming and critical juncture whereby the trajectories of their depression experiences shifted significantly. We can best explore the implications of this shift in trajectory in two ways; the initial response located within and shortly following initial professional contact, and the ongoing and longer-term implications for the women as they incorporate information from this context into their understandings about themselves, their experiences, and their futures.

As a starting point to exploring this shifting trajectory, it is useful to remind ourselves how the women positioned themselves and their distress just prior to entering the professional help arena. For most of the women in this study, taking the step to seek professional help was not a decision reached easily, nor necessarily through their own deliberated choice. Initially the women had constructed their depressive experiences as an inevitable response to the taken-for-granted conditions of their lives. However, the continued and increasingly distressing nature of these experiences had provoked each of the women, to varying degrees, to reach a point where they came to view what was happening to them as evidence of personal failing. Given the nature of their experiences and the shame and guilt thus generated, the women had talked about various ways they employed a 'mask' to contain and hide this from themselves and others. The employment of this mask required considerable energy and was not a strategy able to be maintained for any extended period. When the mask became untenable as a containment strategy, the women found themselves in a position where they or someone close to them felt professional help was necessary. By the time the women did seek professional help, the level of distress they were experiencing was for some extremely high.

Susan told me about how she felt just before she entered the professional help arena, *"Well I got to the point where, you like - the kids are playing on the floor, and I wouldn't pick them up. I remember sitting in the lounge one day and staring at the wall for about two hours, three hours and I never spoke to them, never played with them. I just couldn't bring myself to play with them. It's like you almost hate them, well you hate the fact they're so much work, but then you get to the point where there's nothing, there's no feeling... no feeling at all. It's bizarre, no emotion, you are totally and utterly blank. You're numb. It was like it was happening to*

someone else. You go numb, you go blank and then you feel hopeless, that's the worst part".

JB: "Can you tell me about the hopelessness?"

Susan: "You wake up after 1 ½ hours sleep, and you think I have to do this all over again, what's the point, what is the point, I ended up walking around the house saying what's the point – it's never going to end -and then you look at the clock and it's only 8.30..."

JB: "Is this when you decided to get some help?"

*Susan: "yeah I just got up and there were dishes on the bench and I just couldn't deal with it, and I thought, 'I can't do this anymore, that's the end of it. **I cannot do this anymore**'. (With emphasis)*

Most of the women described similarly high levels of distress and, although fearful of how others would construct this distress, they reached a point where they could no longer contain this, nor continue with it.

Professional help - receiving a diagnosis. In New Zealand, General Practitioners (GPs) are the gatekeepers of the Primary Health Care System and, as such, all funded care originates with them, including referrals onward to primary and secondary mental health services. The women all entered the professional help arena via their GP and interestingly, although two of the women did see a private counsellor as a first step, referral to a GP for assessment and treatment was part of the first appointment. The women reported talking in detail with their GP about the various external stressors in their lives and they answered questions about frequency and severity of symptoms.

I outlined Kate's story and her circumstances in the previous chapter and here she tells us about a visit to her GP for an unrelated matter. She says, *"I went to see my GP one day because I had hurt my ankle and when I walked in, he asked me how I was. We had known each for a long time and I told him I was OK. He said "Just OK, that's not like you", because I am a real bubble of joy usually. And I said that I was just OK and he asked me why just OK, and I broke down really and told him I was really, really tired and kind of empty, and felt like I was trying incredibly hard all the time to keep everything rolling in my life. He asked if I cried every day, and I said I would if anyone listened but they don't so I only cry 2 or 3 times a week".* They went on to talk about some of the things that were happening in Kate's life and the many different strands she was managing simultaneously. Kate continues, *"We talked a little bit about some historical events in my life, and for the first time, I realised how much effort I put into being Um a good person I suppose. You know doing what I thought I needed to do to fulfil my sort of role in life, and I probably never acknowledged just how much energy I put into, my life and friendships, and relationships and helping people and stuff".* I asked her about this role

which she described as, “...you know, very much the looker-afterer, and very much the positive cheery, keeping everyone with their chin up”.

Kate told me she spoke with her GP for some time about these experiences, past and present, and how difficult these had been and were currently in her life. She recalled feeling noticeably better after verbalising these struggles. She said her GP was supportive and spoke with her about depression, chemical imbalances, serotonin, and using medication to correct these imbalances. He prescribed antidepressants which Kate began using. She went home and talked with her husband, she says, “it was like saying stop the bus, I can’t do this all by myself. It was like handing over some of the reins”.

Another woman, Angela, tells how she finally decided to seek professional help after exhausting all the strategies she could think of to manage her increasing feelings of distress, exhaustion, and demoralisation. She had researched depression and its management via the internet and had understood that increasing her exercise and watching her diet, getting more sleep and taking time out for herself, were tools she could employ to shift these depressive-like symptoms. However, when these failed to achieve the hoped for effect and she continued to feel overwhelmed, she decided she had no choice but to seek professional help. She tells how she felt at the prospect of doing so, “I was scared of not knowing what to do and then I admitted I did know what to do but that I was scared of telling a stranger I needed help. I had no real reason to be so unhappy; I had nothing to hang my hat on... I felt so stink because I thought I could cope and I couldn’t and so then I tried to work out why I couldn’t, am I not strong enough, do I have a mental problem? That freaked me out – look at the connotations of that”. She told me how making the decision to go to her GP had been very difficult but was helped by the knowledge that he had experienced some quite public difficulties that were likely to make him less judgemental. In addition, during a long period where she had been undiagnosed while suffering from [name of organic condition], this GP had known her and was therefore unlikely to see her as a hypochondriac, something she admitted to being fearful about. They spoke at length about her current situation and some of the conditions of her life that were causing her distress. They spoke about the immense financial pressures facing her family and their business, the shame and guilt about the possibility of bankruptcy, and the concern for their employees. They talked about her relationship with her husband; her role in supporting him through this time but the ensuing loneliness and isolation that arose for her as he worked “around the clock” and was increasingly emotionally and physically unavailable as he tried to manage this crisis. They talked of her children and other family relationship commitments, and of managing ongoing health concerns. She told me that she had “confessed” to her GP

something she had kept hidden until that time, and which remains, apart from her interview with me, unspoken. She described the relief at having verbalised this as immense. *“It was like going up six-rungs on the ladder of the deep, dark well. I could see the sunshine again”*. She said her GP then went onto explain that having heard her story and how she had tried to manage, *“...he felt her body had a minor chemical imbalance and would benefit from taking antidepressants to correct this”*. Although somewhat reluctant to take medication, she felt *“Okay”* after talking it through with her GP. She described feeling relieved at his diagnosis because now she had somewhere to hang her hat. She had a *“legitimate reason”* for feeling the way she did that had been given to her by someone experienced and trained. Angela said it was *“Okay to put a label on it now (a) because it was minor and, (b) it was chemical, so physical versus mental. There’s a stigma attached to mental”*.

I stated earlier that we could best explore the transformation in the women’s depression trajectories after entering the professional help arena by focusing on two distinct timeframes, the initial, and the ongoing. I have included these synopses to illustrate the unfolding of the initial response to receiving a diagnosis and to show the transformative process that took place when the women in this study spoke about their distress with their GPs. In the above synopses, the women sought help distressed and demoralised. They leave this encounter expressing relief at having received a diagnosis. The following discussion focuses on this shift in the trajectories of the women’s depression experiences and explores this initial response to entering the professional help arena.

We know from the previous chapter that prior to seeking help the women had drawn on primarily social, relational, and material aspects to account for their distress, and how as time went by they had come to believe that their distress was indicative of their failing as individuals and as women. During the course of this professional encounter, the women discuss the contextual aspects of their experiences and resulting depressive symptoms with their GPs. For most of the women, the act of speaking aloud what they had sought so hard to hide was in and of itself a source of relief. The cathartic nature of this speaking out whilst interesting, and worthy of note is however, not the focus of this analysis. When the women have had opportunity to outline their experiences and depressive symptoms, the GPs give the women a new way of making sense of it, a new way of understanding their distress; they receive a diagnosis of depression. For some this was presented as *“you have a touch of depression”*, for others this occurred after answering questions from a checklist and being informed that their scores indicate they have depression. Regardless, the women understand that their symptoms are consistent with criteria for a diagnosis of depression. This important piece of information,

the medicalisation of their distress, marks the turning point in the women's depression trajectories. As Kelly said, "*the diagnosis was important because it made me think I had something wrong with me and it's not just that I am weak and stupid which is very much where I had been*".

Receiving a diagnosis can be a defining act. The impact of labelling (diagnosis) has been a controversial and highly theorised topic over several decades. Originally conceived of as a call to explore how societal reactions to those labelled as deviant played a part in the development of deviance identities, this early proposition has been extensively applied to explore the implications of labelling as it applies to mental disorder (Link, 1987; Link, Cullen, Struening, Shrout, & Dohrenwend, 1989). These studies have explored labelling effects with regard to issues such as rejection, demoralisation, and self-devaluation as well as exploring their relationship with various aspects of stigma. The implications of receiving a diagnosis and the subject positions available through diagnosis are important aspects of the women's stories - as Angela stated, "*...now I felt like I had a legitimate reason to feel the way I did. The risk of being weak or self pitying or hypochondriac had gone*". However, the manner in which a diagnosis is constructed and the subject positions made available are critically important in understanding the implications for the person receiving the diagnosis, not only in terms of how they see themselves, and in terms of how they might take up this diagnosis, but also for treatment decisions and choice. Thus, it is what happens next that I am most interested in and marks such a critical adjustment to the sense-making trajectories of these women. Depression in this context is conceptualised within a medicalised explanatory framework - the GP tells the women that depression is a biochemical illness caused by an imbalance of Serotonin, a chemical in the brain responsible for mood. Antidepressants are the treatment of choice.

Medicalised understandings. The process of defining a problem in medical terms through the provision of a diagnosis and using a medical framework to understand and manage it has been termed medicalisation (Conrad, 1992). The broadening range of conditions to come under the "clinical gaze" (Foucault, 1973) - the medicalisation of a range of human ailments - has long been a focus of analysts who have been writing about the process for several decades (Conrad, 1992, Illich, 2003; Riessman, 1992; Rose, 2006). Although the term itself does not automatically denote a pejorative position, interest in medicalisation has primarily focused on previously nonmedical problems deemed to have become inappropriately medicalised (Conrad, 1992). For example, feminist writers have written extensively about the medicalisation of the female body and the gendered underpinnings of women's higher rates of medicalisation (Blum & Stracuzzi, 2004; Figert, 1995; Riessman, 1992; Stoppard, 2000; Ussher, 2010). In Western

society, because of normal life events such as menstruation, pregnancy, childbirth, and menopause, women's exposure to the medical world is more prevalent, and thus they are far more likely to have their experiences medicalised (Currie, 2005). In recent years, feminist critiques of medicalisation have raised concerns that employing a medical diagnosis, such as depression, to account for women's distress focuses attention on the woman's body and positions depression as a "real entity independent of perception, language or culture" (Ussher, 2010, p.10). This in turn effectively renders stressful social aspects of women's lives such as poverty, sexual abuse, and violence invisible, and negates the economic, political, and discursive aspects of women's experience (Gardner, 2003; LaFrance, 2009; Stoppard, 2000;). In an effort to make explicit the social construction of illnesses such as depression, researchers point to cultural differences in the expression and conceptualisation of experiences such as sadness and melancholia. Japan is cited as an example of a society where prior to pharmaceutical companies marketing a new disorder, *kokoro no kaze*, no term for even mild depression existed (Currie, 2005). Currie further points to a statement from a Japanese psychiatrist, Tooru Takahashi, who commented that in a Japanese context, experiences such as melancholy, sensitivity, and fragility, were not negative things – prior to the promotion of SSRIs, it had never occurred to them to try and remove them.

Social constructionist and feminist writer Jeanne Maracek suggests, "...depression is not something people have, but a set of practices authorized by the culture through which people express to others that they are suffering" (Maracek, 2006, p. 303). However, Ussher (2010) reminds us of the embodied nature of women's depressive experiences and cautions that in positioning depression as solely a discursive construction there is a risk of seeming to negate the very real misery of women who suffer depressive experiences. It is important that in making explicit the social construction of *theories* of depression, it does not imply that the *suffering* is not real.

In this study, all of the women had their experiences medicalised. Conrad (1992) writes that medicalisation occurs on at least three distinct levels. He suggests a conceptual level whereby a medical vocabulary is used to define and describe the problem; an institutional level where a medical approach to treatment is legitimised and physicians may become gatekeepers for services that are only available through organisations that adopt this definition; and thirdly, an interactional level which involves the patient-doctor dyad and sees the problem defined and treated from this medical position. I intend to draw on elements of this broad framework to explore the experiences of the women as they had their distress medicalised; to examine how they utilised this information and incorporated it into their current conceptualisations; how they

experienced and made sense of the treatment that followed; and lastly the implications for them in the trajectories of their depression experience. Exploring the subjective world of those experiencing distress, and the ensuing medicalisation of that distress, in order to gain understanding of this complex process is worthy of attention.

Taking up a diagnosis of depression. All of the women receive a diagnosis – a biochemical construction of their distress. How they take up this diagnosis of depression and the meaning that it holds for them is by no means a straightforward process but it is an important one given its status as a critical juncture for the women in their sense-making trajectories. Rose (2003) in his article titled ‘Neurochemical Selves’ states,

“The significance of the emergence of these new pharmacological treatments for mental ill health lies not only in their specific effects, but also in the way in which they reshape how both experts and lay people see, interpret, speak about and understand their world” (p. 15).

Although Rose’s point here relates to a wider exploration of the shifting conceptualisation of the biochemical individual in an increasingly biochemical world, it is relevant here as a reminder that these shifts in conceptualisation may have far reaching effects for individuals and society that should not go unexamined. We can begin by exploring what takes place at the interactional level within the patient-doctor dyad whilst acknowledging that what takes place at this level does not occur within a vacuum, but rather is located in a cultural and social setting. We will explore some of these contextual aspects affecting the medicalisation of the women’s distress as we move through our exploration of the women’s initial responses to diagnosis.

Returning to the women - we know how they conceptualise their distress as they enter this interaction and we know that the doctor offers them a new biochemical conceptualisation of their distress. We also know that the women experience a sense of relief at hearing this diagnosis. Where does this relief stem from? Given that prior to this encounter the women had not drawn on any biological or hormonal understandings in constructing their distress, at first glance this would appear to be a significant mismatch in conceptualisation. Differences in explanatory models between patient and physician are thought to have a major influence on the treatment process and significant mismatches between the two may lower the likelihood of treatment acceptance (Hwang, Myers, Abe-Kim, & Ting, 2008; Wittink, Dahlberg, Biruk, & Barg, 2008). However, if we move in closer to examine the process unfolding here a number of elements stand out. A crucial aspect in understanding this process requires us to remember that the distress the women are experiencing could be conceptualised in a number of different ways, and at various different points in history, it certainly would have been (Greenberg, 2010). The

women have already formed their own conceptualisations about this and the bottom line for most of the women is their sense of failure to perform adequately, without being distressed, as women, wives, mothers, sisters, and daughters. Alternatively, one of the ways their distress can be conceptualised is as depression, and this in turn leads to another set of possibilities depending on how this diagnosis is constructed. There are various etiological conceptualisations of depression, each dependent on the paradigm from which theorising emerges. Each of these make available different subject positions for anyone receiving a diagnosis and this idea is one we will return to again and again as we follow along the women's trajectories with them. In recent times, contemporary conceptualisations of depression have tended to promote and privilege a biochemical explanation of depression. It is this conceptualisation of their distress that is presented to the women and as such, offers a way to move away from an explanation of individual flaw to a less morally laden biochemical explanation; they are not weak and useless, nor are they bad mothers, wives, and women, instead, they have a physical illness. The women experience a sense of relief, culpability shifts. Angela's story illustrates the importance of conceptualisation when she talks of being offered a legitimate reason for feeling the way she did but highlights that this afforded relief and was acceptable to her because it was constructed as being of physical rather than mental origin. It is important to highlight at this point that for most of the women that they might have had a mental illness was not an idea they had entertained, and so what this conceptualisation initially offers is protection from their construction of themselves as flawed women.

It is clear that the biochemical model offers the women the possibility of a shift in subjective assessment. As powerful as this may be, it is unlikely that taken alone this would be a sufficient condition to account for such a transformation in their explanatory models. However, this does not take place independently of other social and cultural aspects of medicalisation. Alongside the subjective possibilities offered, a number of elements embedded in the patient doctor dyad and the surrounding cultural milieu further facilitate the likelihood of the women taking up this new conceptualisation. Turning firstly to the immediate patient doctor dyad and drawing on Davies and Harré's Positioning Theory (1990) and social constructionist understandings, the position of expert and layperson or professional and patient generated upon entering medical care become visible and influential elements within this interaction. Several of the women referred to the professional training of the GPs and felt provision of a diagnosis from a medical professional "*with extensive training*" offered 'legitimacy' to their distress that was unavailable elsewhere. Discursive practices and medical language employed in this setting further support this medicalised discourse of depression and position it as 'objective' and grounded in scientific research therefore supporting its validity and status as 'truth' (Burr, 2003). Additionally, no

other explanatory models were forthcoming in this interaction, leaving limited possibilities for the women both in terms of their appraisal of self or in terms of what to do about their distress. Counselling was not routinely part of the treatment package and those offered onward referrals spoke of it as secondary to medication, and with a waiting list of 6-8 weeks.

This tendency to giving explanatory priority to biological mechanisms whilst positioning other aspects of experience as ancillary or even irrelevant is often referred to by critics of the scientific method as ‘dualist’ and ‘reductionist’ (Stoppard, 2000). Reductionism refers to a process whereby a complex and multi-layered problem is reduced to a simple lower level cause and effect equation in order to generalize findings, be objective, and provide predictability. The medical language employed in explaining the etiology of their distress to the women by privileging the biochemical underpinnings, further reinforces the ‘truth’ status of such explanations and increases the likelihood of the women taking up this new conceptualisation. Interestingly Thomas-McLean and Stoppard (2004) found that even when doctor’s work with patients and their lived experiences of being depressed did not fit comfortably into a medicalised discourse of depression, doctors continued to draw upon medicalised discourses as a routine matter of practice. As the authors suggest, this is perhaps not surprising given that within their training, this medicalised discourse of depression is the most readily available. While I do not wish to delve into this particular area too deeply, numerous studies have explored a range of other factors that may contribute to this tendency to draw on medicalised discourses even when faced with the clearly contextual complexity of this phenomenon. These are worthy of mentioning in that they offer some context to what is clearly such a significant shift in conceptualisation for these women. I would suggest they could include factors such as the nature of acute care within primary health services where short appointment times and a shift from family doctors to a more locum-based care makes attending to complex emotional and situational aspects of patient’s lives more problematic. In a recent popular New Zealand monthly magazine *North and South* (January, 2011) – the convenor of a recent symposium on Mental Health in Dunedin, New Zealand - Monika Clark Grill - suggested that GPs sometimes prescribe because they are anxious not to miss the possibility of depression. She goes on to say, “There is a sense that by giving medication, you do something real and visible. It’s a big, big anxiety that they’ll miss it and someone suicides” (p.67). These more direct influences, whilst important in their own right, are situated within, and intrinsically related to, broader social, historical, and political forces. These forces play a part in what Zita (1998) refers to as a “diagnostic bracket creep”. This process is posited to arise as novel medications are found to have a positive effect on a broadening range of psychiatric conditions – resulting in a blurring of diagnostic category distinctions (cited in Metzl & Angel, 2004, p.577). This in turn, results in

an ever-increasing number of conditions that are treatable by one class of psychiatric drugs (Shorter, 1997). Rose (2006) discusses a number of forces he believes play a part in this outward extension of the borders of pathology and normality. This includes a shift toward thinking “of ourselves as individuals whose moods, desires, conduct and personalities are shaped, in part, by the particular configuration of our neurochemistry, and which can therefore be moderated or modulated by acting upon that neurochemistry, acting upon our brains through drugs” (p.481).

In returning to the women’s stories and bound up with all the elements above is the likelihood that within this dominant biochemical discourse the possibility of relief becomes available. The provision of antidepressants as a ‘safe and effective’ way to manage debilitating symptoms and the hope that this would be achievable in the short term was something all the women noted as important. Helen told me, “*I wanted an end to these symptoms and I wanted it quickly*’. Kelly talked of her GP referring to antidepressants as ‘*something that should be in the water supply*’ and this certainly enhanced her sense of them being safe and useful. Chapter 5 - Section 1, contains an in depth discussion regarding the construction of anti-depressant medication as a safe and effective option.

Other elements in the wider social environment that support medicalised discourses of depression and thus facilitate the likelihood of taking up such a diagnosis have been the focus of researchers over the last decade. In an increasing number of publications, women’s distress and unhappiness has been constructed as ‘depression’ and conceptualised as arising from biochemical imbalance. Recent years have seen a growing body of research that explores the ways in which depression is conceptualised in academic, scientific, and popular media publications as a biochemical illness (Clarke & Gawley, 2009). Gardener (2003) explores how “dominant depression discourses of scientific and consumer literatures circulate through culture in tandem, constructing a popularized “common sense” script of depression that is difficult for consumers to think outside of” (p.106). Furthermore, scholars have extended this exploration to examine how popular discourses around medications such as Prozac, have women as their targets in scientific publications, advertising, and other mass media. In a guise of apparent gender-neutrality, these publications are posited as laden with gender stereotyping - with women as their targets, these representations take on a decidedly feminine character (Metzl & Angel, 2004; Blum & Stracuzzi, 2004). Several of the women referred to literature they had accessed via the internet that referred to the biochemical nature of depression and clearly marked depression as an illness. One woman spoke of television programmes where people took Prozac for depression and were seemingly much better off for doing so.

It is clear that a wide range of complex factors are involved in the construction of women's distress as depression, and the construction of depression as biochemical in origin, best treated with antidepressants. I have touched on some of the aspects most clearly highlighted in the women's stories that contribute to the medicalisation of their distress. These include the possibility of a subjective shift in self-appraisal and the relief that stems from this; the expert positioning of the professional and the use of medical language to support the truth status of this discourse; the provision of a possible means to reducing distressing symptoms and, broader discursive practices that construct women's distress as 'depression' in medical, political and popular publications. We have seen a significant shift from the women's pre intervention explanatory models that privileged the complex contextual world they inhabit, to an explanatory model that privileges biological mechanisms. This has been a critical juncture in the women's depression trajectories and the initial shift is illustrated in the next section that explores what happens following the initial appointment with their GP, how the women return to their lives with this new conceptualisation and what actions become possible or constrained as a result of their taking up this new framework.

I have a diagnosis. Having a way to 'legitimise' their distress via medical diagnosis was clearly a relief for the women. A medical diagnosis also gave the women a means of communicating their distress to significant others and as we saw in the earlier synopsis from Kate, this offers a way to ask for help and reduce responsibilities. Susan summed this up clearly when she spoke of what changed after diagnosis, *"It allowed me to let go of my responsibilities a bit more and to admit that I was feeling as bad as I was feeling. Yeah, and to open the floodgates a bit which needs to happen and get it off your chest more, and you know, that you do have a problem and that it is real and that it's not imaginary....Couldn't do that before because it wasn't official"* (with emphasis). Sara spoke of the additional help around home-based responsibilities that was initially forthcoming when she first received a diagnosis. She also told me how it temporarily changed her husband's behaviour, *"He started taking some time off work, and we walked on the beach and spent just him and me time"*. This initial change, so different from keeping their distress silent, using an energy draining 'mask' to hide their pain from others, and feeling unable to ask for help for fear of what it would mean to do so, is of profound relief to the women.

Paradoxically, once diagnosed, and even with this biochemical explanation, the stigma of depression must be countered, it is still not visible and its 'real' cannot be seen or truly located. An etiological uncertainty about depression requires the women to work to protect themselves from the potentially pejorative perceptions of depression as a mental illness. Goffman (1963)

defined stigma as an “attribute that is deeply discrediting” and reduces the stigmatized person “from a whole and usual person to a tainted, discounted one” (p. 3). Researchers from various disciplines have been exploring the relationship between stigma and mental illness since this initial formulation of stigma by Irving Goffman (Barney, Griffith, Jorm, & Christensen, 2006; Link & Phelan, 2001; Schomerus & Angermeyer, 2008; Schomerus, Matschinger, & Angermeyer, 2009). The relationship between stigma and help-seeking intentions and behaviour has been central to these studies and yet this complex relationship remains unclear. However, social constructionist researchers in the area of depression have explored conditions that may contribute toward stigma associated with depression as a psychological disorder. Assumptions of Western medical and psychiatric discourses that presume dualist notions of body/mind, and objectivity/subjectivity, privilege scientific inquiry in its striving for value free and objective collection and analysis of data. They also lay the social and cultural conditions whereby depression as a psychological condition, carries with it a number of moral overtones (Gordon, 1988; LaFrance, 2007). Depression as a psychological condition is a problem of the mind; not only does this mean it is not visible and so therefore not verifiable in the same way as observable, bodily trauma would be, but is also determined for the main part by subjective accounts from the sufferer and therefore its status as ‘real’ is certainly questionable. Questions of volition and blameworthiness become central and sit alongside the stigma of being ‘crazy’ in a society that defines abnormal and normal behaviour in such a way that it is separated from its cultural, historical and political underpinnings. Further complicating these issues is a lack of semantic clarity when using the term depression. The usage and understanding of the word depression is heavily context dependent. In professional terms, it signifies the presence of a mental illness, regardless of the origins of this disorder, and is seen to lie within the individual (Stoppard, 2000). In lay terms, the use of the word depression can denote a continuum of normal experiences none of which may be a diagnosable disorder. The idea that one can ‘snap out of it’, that one is being self-indulgent, or that one is experiencing nothing different from what most people may feel at one time or another, contributes significantly to the ‘lack of real’ that the women refer to throughout their narratives. Angela stated that this was a powerful reason in her not communicating her distress or diagnosis with significant people in her life. She told me telling her mother was out of the question as, *‘she would either tell me to snap out of it or everything I felt would then be put down to me being depressed’*. A diagnosis of depression, constructed as a psychological condition is thought to stem from personality and cognitive deficits residing within the individual and brings with it the possibility of being weak, self-indulgent, lazy or hypochondriac, untrustworthy, and ultimately blameworthy. A psychological disorder confers the status of being mentally ill and along with it, all the connotations it might bring.

Sara's story highlights the implications of a diagnosis of depression as a psychological condition, rather than as biochemical condition. After admittance to a psychiatric ward for overwhelming distress, she told how she actively resisted the diagnosis of depression. Depression constructed as a psychological condition offered none of the relief experienced by the other women. She said, *"I didn't want to be classified as depressed – to be judged as crazy, be locked up and have the key thrown away"*. Later, having accepted the diagnosis of depression, she worked to construct depression away from mental illness and the pejorative connotations of such a label. Sara talked of how she felt after being admitted to hospital,

Sara: "I felt I did not need to be there, remember the people in there, now they have not got depression, they have got ISSUES, you know actual issues".

JB: "So there is a difference?"

Sara: "There is definitely a difference between being emotionally and physically exhausted and needing help compared to where they hurt people or commit crimes – those are mental issues".

As I stated earlier, even for those women who had their distress conceptualised in biochemical terms, separation from mental illness and questions of morality were not foregone conclusions. Schreiber and Hartrick (2002) found that women in their study used the biochemical model as a means to managing the stigma of depression. Like the women interviewed in their study, it certainly seems that the women in the present study use the biochemical explanation as a way of positioning their depression as arising from biological factors, rather than as a mental illness. I will discuss how they do this in the next section. However, it is important to remember that initially the women take up this explanation as a means of protecting themselves from the idea of being a 'bad' woman. It is only after diagnosis that the women need to protect themselves from the stigma of depression as a mental illness and this is where the biochemical explanation is used to position depression as a problem of the body in hopes of exonerating the women from the morally laden connotations of depression as a psychological condition.

A new way of talking. What is evident in the stories of the women after diagnosis is the shift in language when talking about their distress. They now refer to their distress as 'depression', they have taken up this diagnosis and are using it not only in their discussion with me, but also in their descriptions of how they spoke about their distress with other people. All of the women used statements such as *"I have depression"*. In the early stages of their stories, the women spoke of what was happening to them as a verb, a response to their situation. Following diagnosis, they described their distress as a noun, an entity that was unpredictable and out of their control. This way of speaking helped to locate the problem away from their own reactions, to a problem of the body – problems of the body being unintentional and 'real'.

In order to highlight further the physical nature of this entity, several of the women drew parallels between depression and supposedly accepted physical illnesses such as diabetes, asthma, and high blood pressure. Kate says, “*Anti-depressants have made a huge difference in my life and I see it as no different to taking medication for blood pressure*”. At another point in the interview, she offers an analogy to explain how the anti-depressants help, “*The medication allows my brain to stop. It’s like someone having an asthma attack and finally getting their inhaler. You know you can function but it’s bloody hard work*”. Helen told me when talking to her mother in law she was very quick to point out to her, “*It’s actually about the serotonin level in the brain not about being weak or anything like that*”. She clearly felt there were limited options for talking about her distress; it stemmed from being weak, or it stemmed from a physical illness. Others also stated that they were cautious in sharing this diagnosis with those around them for while they spoke of depression as biochemical in origin, that others would perceive it this way was less certain.

It is perhaps not surprising that the women compared depression to physical illnesses thought to have a genetic component. The women referred to their depression as being genetic and listed other family members who have or had depression. Sara says, “*My mother suffers from it as well, it’s definitely genetic, they (doctors) even told me it was genetic*”. Here she not only highlights the family history but also draws support from the medical profession to back this up. Another woman, Kate, whose mother suicided after a long period of depression, talks extensively of the extended family history of depressive-like illnesses and says she has finally accepted she “*has the family lurgy*”. In positioning depression as genetic, some of the women also positioned depression as something outside of their control. They spoke of depression as inevitable given their genetic make-up and something they would need to learn to manage. Other ways the women demonstrated how they had incorporated this medicalised construction of their distress into their understandings was their talk of finding out what was “*wrong*” with them, thus locating the source of their distress from within as well as opening up the possibility of being “*cured*” or “*fixed*”.

It is clear the women picked up the diagnosis of depression and used the biochemical explanation as a means of locating the origin of their distress as physical and so essentially separate from their character. What was equally clear was the uncertainty contained within their stories about how exactly a chemical imbalance could result in this distress or, what this then said about the contextual aspects of their lives of which they had spoken of at length in the pre-intervention part of their narratives. How the women

made sense of these conflicting positions and the implications for the women as they continue with their lives following diagnosis forms the last Chapter of the findings.

Chapter 5: Findings and Discussion

The Aftermath

This chapter is about the women's experiences following diagnosis. Earlier, I spoke of exploring the implications of the women's shift in their depression trajectories over two time frames – the initial response - explored in chapter 4 - and the longer-term implications for the women as they continue with their daily lives armed with a new biomedical conceptualisation of their distress. This chapter explores these longer-term implications following diagnosis and beginning treatment with antidepressant medication. This chapter sees the women face a sense-making dilemma; for some this comes earlier than for others, but regardless of when it arrives, it is clear that it arrives for all the women - how to make sense of the ongoing distress they experience as they go about their everyday lives. The following synopses/excerpts have been included to illustrate this sense-making dilemma apparent in all the women's stories of life after diagnosis.

Sara talks of the confusion she experienced as she continued to experience what was at times, high level of distress. She spoke of the frustration she felt at not being able to work out why she was feeling the way she did. She referred to this as being *“like a rollercoaster”*. She talks of the small things that might initiate a downward spiral such as embarrassment over her appearance – of her sense of herself as being unattractive - she talks of how this would take on more and more significance, but how this also made her feel *“pathetic”* for worrying about such *“silly things”*. She would then turn to the other aspects of her life describing how it was not really this one small thing it was actually everything that surrounded this. Some of these surrounding aspects of her life included such conditions as a range of relationship difficulties with immediate and extended family and having recently experienced a very difficult birth with the ongoing implications of having a child who was born pre-maturely. She also talked of the loneliness and exhaustion she experienced with her husband working all the time leaving her feeling like a solo mother. She described herself as incredibly sad and angry at the way things currently were between herself, her father, and his new wife who appeared to want nothing to do with herself or her children.

Sara then goes on to tell me about how confusing this all was and how she could understand why the medical and mental health practitioners she saw had so much trouble working out what was wrong with her. She says, *“They give you mood stabilisers ‘coz a lot of it’s mood. It’s trying to balance your mood you know and not actually the depression. It’s the moods that are*

causing it, and especially in women because half the time we might not actually be depressed, it's our moods – we go through hormonal changes – we get depressed on just mood changes. It's a real fine line. I know I get depressed because I cry a lot – that's definitely depression". Sara goes on to talk about the differences between depression and mood. She says, *"That's definitely depression um then you get the mood type of thing, but you get the depression with the moods...It's like hormonally you get a bit down but is that a mood thing that you need mood stabilisers or do you need anti depressants or do you need both? I can see how hard it must be for them to figure out what sort of medication you actually need".*

Another woman, Rebecca, spoke of her struggles to make sense of her experiences of depression and experiences following treatment. She talked of her life before children - of sexual abuse as a teenager and the ongoing sense of shame that ensued. She spoke of being introverted and shy, in a small town that saw this as *"wrong"* – she spoke of how it made her feel to be told there was something wrong with her for being shy. Rebecca talked about having a parent with mental health issues that led to extreme social withdrawal, and she talked of a difficult, sometimes frightening relationship with her mother. When she had children, Rebecca, spoke of the fear she had of being able to care for her them when she felt so angry and unhappy; she spoke of trouble in her marriage and the possibility of separation; and she spoke again of the problematic relationship with her parents. Throughout this, Rebecca talked of the abuse she had experienced and her wonderings about how and why this may have happened – what role she played in this – why did he choose her? When Rebecca sought help following the birth of her second child, she described a visit from a public health nurse who she recalls told her she had post-natal depression. She remembers thinking, *"This is very convenient, – surely that's too easy. I felt like this before too so how does that fit in.* At that time she was given anti-depressant medication and as she said *"left to my own devices"*. She described her ongoing struggle to make sense of her reactions. She said she wondered now whether maybe this was all down to her being depressed. At the same time she talked of feeling embarrassed when she saw different health visitors because she did not want her experiences of 'post-natal depression' to be seen as separate from her background. As Rebecca moved through her story she talked of how she struggled to make sense of her varied emotions and reactions – she found herself constantly asking herself whether she had a right to feel the way she did, or was it simply because she was depressed. She described herself as oscillating between believing she had valid reasons to feel the ways she did, and feeling that these were merely symptoms of depression. She stated she hated this confusion and uncertainty –she described it as a *"horrible place to be in – I hate feeling like this"*.

These synopses illustrate the sense-making dilemma the women face and their struggles with the uncertainty generated within this space. In exploring how the women came to view themselves, how they constructed their experiences of ongoing distress following diagnosis and treatment, and the implications for the women of these constructions, it is important to also explore the conditions that form the 'local realities' which they inhabit. In order to make sense of their experiences, the women draw on available discursive constructions surrounding distress and depression, generated within a broader cultural, political, and economic context. This Chapter focuses on three particular discourses whose power is evident throughout the women's narratives, and explores how they work together to form the conditions that surround the women in their trajectories of depression experiences. Section One explores the symbiotic relationship between a medicalised, biochemical discourse of depression, and prevailing discourses around anti-depressant medication that construct Selective Serotonin Reuptake Inhibitors (SSRIs) as safe, effective, and the first and preferred choice for the treatment of depression. I explore how these 'truth' claims produce experience and subjectivity whilst also rendering the social and cultural aspects of the women's ongoing distress invisible. Section Two, explores how, assisted by a lack of alternative discursive practices for speaking about depressive experiences, contemporary discourses around femininity and motherhood support these powerful discourses in their invisibility work.

Section 1: Medicated living.

The use of anti-depressant medication is an important feature throughout the women's narratives. At the time of interview, nearly all of the women were still using anti-depressant medication and their relationship with these medications forms a critical part of their ongoing sense-making trajectories. This relationship with antidepressants begins at the time of choosing to fill a prescription and begin a course of SSRI's, and continues for the duration of their use and beyond. The prevailing medicalised discourses around depression and anti-depressant medication as the first and most effective line of treatment are powerful aspects of the women's discursive worlds. These ideas have become such commonplace, accepted 'truths' that as Cohen (2004) states, "In everyday discourse the word "treatment" is synonymous with "medication" because the place of psychotropic or psychiatric medication in the mental health system is pivotal" (p.1).

Diagnosis determines treatment. The prevailing biochemical conceptualisation offered at the time of diagnosis indicates the prescribing of medication to address the imbalance of serotonin in the brain responsible for depressive symptoms. This would seem a logical action to follow such a diagnosis. However, the suggestion of such a simplistic relationship between diagnosis

and treatment is deceptive and is supported by the 'rational use of drugs' paradigm predicated on the notion of, "the judicious prescription by well-informed professionals of well-studied drugs to well-informed patients for well-defined conditions". (Cohen, McCubbin, Collin, & Pérodeau, 2001, p.444)

An increasing numbers of critical researchers and scholars believe this framework inadequate for understanding medication usage and effects in contemporary society (Cohen, 2001, 2003; Nichter & Vuckovic, 1994; van der Geest, Whyte, & Hardon, 1996). Its failure to appreciate the complex, mutually supportive links between diagnosis, medication, and treatment, or to recognise the diversity of contexts, actors, values, and ideas involved in the production, distribution, and usage of medications, is both misleading and unhelpful. Just as discursive constructions of distress and depression as neurochemical imbalance hold symbolic power and have arisen within a broader social and historical context, so too medicines are more than just material substances. Cohen (2001) reminds us that medications are also social and cultural phenomena with powerful symbolic resonance. Embedded within, and affected by this symbolic field, the women strive to make sense of their experiences of diagnosis, treatment, and ongoing distress.

Not just a prescription: the performance of prescribing. The women's relationship with SSRIs is an important one. Not only does it have implications at a physiological level, it also marks the beginning of their relationship with a biochemical explanation for their distress. This relationship has profound implications for the interpretive work they engage in throughout their journeys. The decision to both prescribe and to begin using anti-depressants is a complex one. The provision of a prescription carries symbolic (metonymic) meaning and has many latent functions other than providing a cure for a problem (van der Geest et al., 1996). Firstly, the use of the word 'antidepressant' carries a powerful message, not only with regard to the appropriateness of the medication to the diagnosis, but also with regard to expectations of what the medication will achieve. The prescription provides the women with a form of concrete proof of their 'medical' condition, shows empathy and concern from the practitioner, and validates that there is something actually wrong. Nearly all the women commented that at their initial meeting their GP listened to them and demonstrated "*kindness*" and "*concern*". The cathartic experience culminating in provision of a prescription provided relief and validation that something was "*actually wrong*". As a latent function, prescriptions and medications in this case, shift culpability from individual failing to biochemical failing and thus speak directly to the women's identity. Furthermore, with the provision of a tangible substance, what van der

Geest et al. (1996) refer to as ‘thinginess’, the women and the respective practitioners have a concrete, ingestible means with which to address the problem at hand.

On the other hand, given the chosen conceptualisation, not prescribing the indicated treatment may very well prove problematic for both practitioner and patient. For example, in the case of the GP, surrounded by the ‘truth’ status of these discursive constructions, not prescribing raises questions about ‘withholding’ the indicated treatment. The constitutive power of these discourses opens up the possibility of such an action being constructed as unethical or unsafe. For the women, having been thus diagnosed, how would other options be likely to address such an imbalance in brain chemistry? The power of particular versions of ‘reality’ to shut down other avenues for diagnosis and treatment and to continue to reproduce the ‘objects’ of which they speak is very real. Foucault (1972: 49) describes discourses as “practices which form the objects of which they speak” and here we see this circularity played out. At the same time, conveyed through provision of this medicalised diagnosis and treatment, is another particularly important message about what the ‘object’ is not. A latent function of prescribing medication to fix this biomedical problem is the message it inherently carries about other aspects of the women's experience. This diagnostic conceptualisation, supported by the notable absence of alternative options, relegates contextual aspects of the women's lives to the background. Taking up this diagnosis and treatment makes possible a particular way of speaking about their distress, but within these dominant discursive constructions, it becomes difficult to find ways of talking about other aspects of their experience. We will return to this important idea later. However, in order to appreciate the complex space the women inhabit as they strive to make sense of their experiences, we need to examine further the conditions that form the backdrop to their sense making trajectories.

The women's narratives show they do make a distinction between their physiological responses to using SSRIs and other aspects of their depression stories. Whilst not suggesting it is possible to unravel the links between the women's experience of using anti-depressants and their discursive worlds, for simplicity's sake I have chosen to separate further discussion of the women's relationship with SSRIs into two areas. First, using the distinction already present in the women's narratives, I explore how the women spoke about their physiological experiences of using SSRIs. I pay particular attention to their talk of efficacy in reducing distress, side effects, missed dosages, and withdrawal symptoms. I will locate this discussion within the broader social and cultural arena from which the women draw their understandings around appropriateness, efficacy, and safety. This distinction for discussion purposes is useful in that it effectively sets a scene for exploring the second part of the discussion – how the women make

sense of ongoing distress – Section 2. It is important to explore how both those who prescribe, and those who use these medications come to construct them as the panacea for depression, or at least for providing the most effective management of this ‘disorder’. For it is within the constraints of these understandings that the women must make sense of ongoing distress.

A safe and effective option. Surrounded by all of the above considerations, a particularly important aspect of the women's decision-making around medications was their understanding of SSRIs as a safe, effective, and non-addictive option for treating depression. This understanding was clearly instrumental in their decision to pursue this line of treatment and facilitated certain expectations regarding symptom reduction. Such understandings also have implications for their initial commitment to a biochemical explanation for their distress. The garnering of these understanding clearly takes place within a broader context than just the patient-doctor dyad, however, at this point I would like to highlight how the women spoke about these initial conversations with their GP's about anti-depressant medication.

The women spoke of the initial explanation from their GP that constructed antidepressants as the treatment of choice for depression, seemingly suitable along a wide spectrum of severity. They understood this medication was designed to increase the serotonin in their brain and, as the diagnosis had located the source of their distress as lowered serotonin, these two ideas become mutually validating. Those who did raise questions about whether this medication was addictive received assurance that it was not. Kelly spoke of her GP's comments that everyone should be on them, “...*they should be in the water supply*”. She said she felt greatly reassured when her GP told her, ‘*they are not those super strong drugs; they are only antidepressants*’. Angela who described herself as concerned about taking antidepressants, not wanting to be on them for life, was relieved when she was told her depression was ‘*minor*’ and what she was being prescribed was a low dose. She said, “...*when he explained this, it made it feel OK*”. The women reported a vague understanding that abruptly stopping their medication may have some mild, unwanted effect on mood, although the exact reason for this was not made explicit. The women spoke of being reassured by the information provided, and alongside other contextual elements discussed previously, the expressions of hopefulness and relief present in the narratives about this course of action, are less than surprising. It is clear that who delivers the information and in what context, sit alongside the reassuring nature of the information provided and are powerful aspects in the women's decision-making process.

Following the conversations with their GP's, and armed with this new and reassuring knowledge, the women express an overall expectation that this medication will make a significant difference to their sense of distress. While the women did not report any dialogue

with their GPs about the exact nature of the bodily effects they could expect, they did understand the medication would take about 3 weeks to work. Most of the women do report a change in affect over this period – a *'blunting'* of emotion. Susan describes this as *'like a switch'* stopping the *'incessant ruminating'* and thus giving her a break from the anxiety and exhaustion this created. Kate talks of the antidepressants *"numbing"* her emotions and giving her a break from the intensity of the distress which as she said, *"I really needed"*. Rebecca said, *"...they made you feel less"*; clearly a welcome change at this time. In these early stages of using medication, the women clearly experienced these physiological responses as therapeutic. Accordingly, when the metaphorical power/nature of the term 'antidepressant' works alongside the relief derived from these physiological responses, the women construct these medication responses as evidence of an 'antidepressant' effect. Helen clearly stated this when she said, *"it must be depression coz why else would these pills work?"* This construction effectively serves as implicit reinforcement for the original conceptualisation of a biochemical imbalance and the suitability of medications to correct this. If SSRIs affect nerve transmissions in this way, then surely this is proof of a pre-existing dysfunction within those very nerve transmissions.

Several critical researchers highlight the problematic nature of such reasoning (Breggin, & Breggin, 1994; Moncrieff, & Cohen, 2005; Rose 2007). They point out how using the same line of reasoning, one could construct the effects of caffeine, cocaine, and alcohol, as evidence of a pre-existing defect in the brain. Yet, making assumptions regarding the theoretical validity of pre-existing biochemical abnormalities based on observed drug effects is a particularly powerful discursive practice. These discursive strategies are employed in 'disease centred models' of mental disorders which underlie the chemical imbalance conceptualisation offered to the women (Cohen, et al., 2005). As previously highlighted, these discursive conditions are crucial elements surrounding the women in their sense making journeys. Just as these privilege and afford validity to particular ways of understanding, speaking about and acting upon depressive experiences, the converse occurs with respect to other aspects of the women's lives. The implications of such discursive practices become increasingly apparent as we move through the women's stories about the presence of ongoing distress in their lives.

An inherent part of the women's sense-making derives from their understanding that SSRIs selectively target the serotonin system. Claims of SSRIs' selectivity draw on the widely disseminated premise that it is both possible, and desirable, to selectively target the serotonin neurotransmitters to alleviate depression. This claim arises in a climate where diagnosis takes place through the identification of symptoms. The manifestation of these symptoms is then mapped onto disruption in specific neurotransmitter functioning. Thus claims of specificity in

diagnosis and selectivity in drug action work together to produce the truth claims of neurochemical imbalance, and SSRIs as the first line of treatment (Rose, 2007). Further, scientific, and popular portrayals of SSRIs' safety and efficacy suggest this selectivity is possible without unwanted disruption of other brain functioning, and lends significant credence to their claims of minimal side effects and non-addictive properties. Numerous researchers argue however, that scientific evidence for these claims of specificity is extremely weak. They highlight the lack of evidence supporting serotonin disruption as a causal factor in the complex phenomena that we know as depression and the ongoing failure to distinguish between intense normal sadness and depression as a clinical disorder (Horwitz & Wakefield, 2007). Further, there is extensive evidence suggesting that rather than being specific in their targeting of serotonin, SSRIs actually work across a broad spectrum of molecular brain processes and influence a long-lasting, complex chain of interactions (Breggin, 2008; Cohen, et al., 2005; Currie, 2005; Gardiner, 2003; Medawar & Haddon, 2004; Rose, 2007).

As the women's journeys with medication progress, we see the power that discursive constructions of SSRIs' appropriateness, safety, and efficacy have as they surround the women's attempts to make sense of a myriad of physiological responses. The women draw on these prevailing discursive resources in order to make sense of what is happening to them. Yet even amongst these prevailing discourses, the women do raise queries about side effects and the possibility of dependence. Where they do attempt to seek out additional information about drug properties, this is notably unforthcoming and effectively reduces opportunities for making sense and taking action. The outcome in these instances is one of confusion and uncertainty.

Constructions of side effects. The women spoke about side effects in various ways, indicating a certain amount of individual variation in physiological response. However, as we have discussed, medicines are more than just chemical substances. Just as constructions of efficacy arise within a complex web of social and biological factors (van der Geest, et al., 1996), so too, do assessments of side effects. The women spoke about a range of side effects ranging from dry mouth, loss of libido, weight gain, and initial problems with sleep disturbance, to heightened anxiety, tremors, agitation, and ongoing insomnia. In addition to the individual variation one could expect in physiological response, a number of additional factors appear to be instrumental in how the women construct their experiences of side effects. As reflected throughout the wider depression experience, we see the complex weaving of biological and social aspects of experience played out with regard to side effects.

The women spoke about side effects in two distinct ways. When the benefits, remembering that these are both physiological and metonymic/symbolic, outweigh the perceived costs (side

effects) of using medication, the women spoke about side effects as an expected aspect of using SSRIs – a function of the drug itself. In a ‘cost benefit’ analysis, the therapeutic possibilities offered by continued use of medication outweighed the costs of these side effects; that is, they were a small price to pay. However, other women spoke of quite “*horrific side effects*”. Kelly described her experiences as “*...worse than anything I have ever felt before*”. She said, “*I was barely functioning at this stage. I would burst into tears in the corner. [Husband’s name] was petrified. We didn’t talk about it then but he told me later he thought I was going mad. He was really scared*”. Sara spoke of an endless round of “*horrendous*” side effects counteracted with additional medicines to manage the adverse effects. She described herself as feeling “*...like a guinea pig*”. It would seem that for these women the perceived costs of taking medications far outweighed any benefits of continued use of SSRIs. Yet these women continued their use of anti-depressant medications. Why would the women continue to take medication that rather than providing relief from distressing symptoms, was actually adding significantly to their distress? While there may be many factors that contribute to this seemingly incongruous response to adverse effects of using SSRIs, the women's narratives clearly showed that the expectations of practitioners and powerful discursive constructions around safety and efficacy were instrumental in continued use. The women spoke of their practitioners’ insistence that they should continue with medications despite reports of highly distressing reactions, raising questions about how practitioners listen to lay descriptions of the intensity of drug side effects. The prescribing of additional medications to counteract adverse effects certainly appeared to support the idea they were “*just something you had to put up with*” while waiting for the anti-depressant medication to work. The relationship between discursive constructions of particular side effects as tolerable, and systems for monitoring adverse effects would appear to be a useful one to explore further. The women continued to express hopefulness that SSRI medications would have a significant impact on the original distress despite the disruption caused by their use. It appears that the way practitioners speak about side effects, and the assumptions that underlie advice to continue using medications, has a significant impact on patients’ perception of medication safety and efficacy, and as such, on medication usage.

The continued prescription and use of medications under the above circumstances demonstrates the ongoing commitment to a biochemical conceptualisation and highlights the inherent support it receives from anti-depressant discourses around safety and efficacy. Additionally, and in line with such discourses, those women who spoke of tolerable adverse effects located the source of these as a function of the drug itself. The women who experienced what appear to be quite intolerable and significantly distressing adverse effects eventually came to locate the source of the problem as within themselves. Discursive constructions suggesting that heightened anxiety,

insomnia, and agitation immediately following the use of SSRIs is likely related to the unmasking of a pre-existing bi-polar condition, rather than the action of the drugs themselves, was something these women continued to struggle with despite no previous symptoms of mania prior to starting SSRIs.

Efficacy talk. The women spoke of their concerns around the effectiveness of anti-depressant medication for providing any ongoing sense of relief from distress. This talk is a further illustration of the power that discursive conditions have in shaping subjectivity and possibilities for action. Alongside an absence of alternative constructions of distress, and given the discursive conditions that surround their treatment experience, the women's lack of sustained relief when using anti-depressant medications places them in a precarious position. Given the implications of adjusting their explanatory models, and in line with anti-depressant medication discourses, some of the women made sense of this by turning to the action of the drugs themselves. Despite the lack of evidence to suggest significant advantages in switching anti-depressant medication (Bschor & Baethge, 2010), seeking further help from GPs or, for some psychiatrists, resulted in increased dosages or a change in medication from one SSRI to another. Those women who embarked on this path spoke of the ensuing search for the “*right*” medication. Karp (1996) found similar ‘searches’ in his interviews with people about their experiences with depression. Sara spoke of what seemed an endless search for the medication that would work for longer than a few months. As various medications and dosage levels failed to bring sustained relief, she described her concerns about becoming “*immune*” to the medications in question. This would result in further trial and error searches for the next medication that might offer a measure of relief. Interestingly, researchers highlight concerns around safety and potential withdrawal effects in anti-depressant medication. They point to criteria for establishing dependence in illicit drug use, where the need for increased dosages (immunity) to achieve the same effects, is a defining criterion (Breggin, 2008; Medawar & Hardon, 2004). Helen also spoke of her concerns of becoming “*immune*”, less in the context of medications no longer providing relief, although this was certainly an ongoing feature of her story, but rather, she spoke of her fears about what would happen if she did become immune. When explaining why she had made the choice to reduce her medication when she was feeling “*good*” at the higher level, she said, “*Because I’m always worried that my body will become immune to it, and what will happen if I get worse, I’ll have nothing to fall back to*”. These constructions give rise to a number of questions, not only about the efficacy of SSRIs with respect to their physiological properties, but also the implications of reducing complex phenomena such as depression to their simplest lower level cause and effect equation. Reliance on medications and thus ultimately on medical practitioners, is an issue raised by many critics

of medicalisation (Conrad, 1992, Riessman, 1992). We see here a powerful illustration of the disempowering effects of positioning cultural and social aspects of the women's experience as ancillary or irrelevant. Choices for taking action and making sense diminish significantly when we employ single cause and/or reductionist models in the treatment of depression.

Problems with withdrawal. Some of the women talked about disconcerting physiological and psychological symptoms, arising either through an attempt to withdraw from medication or after missed dosages. They described a range of symptoms including heightened anxiety, tearfulness, distressing visual disturbances, dizziness, and odd motor sensations. These were clearly distressing experiences for the women and they struggled to make sense of what was happening to them. Susan described the problems she encountered when she attempted to withdraw from Citalopram. She spoke of the difficulties she experienced as she tried to work out what was happening to her, leaving her wondering if the problem lay with her. She said she would ask herself if what she was experiencing was imaginary, saying, *'you just think it is all in your head and you're imagining things. It's awful; you just don't know what's happening'*. Helen spoke of symptoms that she experienced with missed dosages and the confusion and uncertainty she felt about what was happening. She told me how she initially thought she was experiencing withdrawal effects but upon seeking medical advice, learned this was unlikely to occur after missing only a few doses. This led her to wonder if *"it was all in my head... maybe it's just all psychological"*. She said, *"...perhaps I was making it up"*. We can see the confusion in these excerpts as the women struggle to grapple with the power of Westernised mind/body dichotomies within the constraints of discursive constructions of SSRIs non-addictive properties. Kate spoke of her experiences with missed doses saying she experienced a *"sleepy tiredness and heavy emotional fatigue"*. She concluded this was evidence of her need to be on medication indefinitely saying, *"I think depression is a constant with me, it's something um, I need to accept and manage"*. When asked if she had ever considered these symptoms related to withdrawal effects, this woman became silent and eventually responded *"I don't know, I've never considered that"*. In the absence of readily available information regarding possible withdrawal symptoms, surrounded by anti-depressant medication discourses that minimise the potential for dependence and withdrawal, the possibilities for making sense of these experiences were significantly limited.

One way the women made sense of these experiences was to conclude the original problem was still present and only kept at bay due to medication. Interestingly one woman did eventually conclude that her experiences upon stopping SSRI use was directly related to withdrawal effects rather than a breakthrough of depression symptoms – however, several attempts at tapering her

medication resulting in intolerable withdrawal effects, led her to conclude that she would need to stay on low doses indefinitely to keep these symptoms at bay. The possibility of mistaking withdrawal symptoms for relapse has been an ongoing concern for many researchers who caution against uncritical acceptance of studies and promotional materials that suggest little or no evidence of withdrawal effects in anti-depressant medication (Breggin, 2008; Medawar, 1997; Medawar & Hardon, 2004).

This section has explored the relationship between the women's' ongoing interpretive work and their understandings of the appropriateness, efficacy, and safety of anti-depressant medication in treating a biochemical depression. These discourses clearly weave together in mutually supportive ways to produce experience and subjectivity. What is also clear is that increasing numbers of researchers are concerned about the discursive constructions of safety and efficacy that surround SSRIs. They posit that the evidence for such constructions is weak and in some cases flawed. These concerns focus on the research design used in clinical trials including issues with the exclusion of placebo responders from trials, difficulties with 'blinding' of studies, and the short time frames of clinical trials. In addition, scholars raise concerns around bias in media representation regarding the safety and efficacy of SSRIs, bias in reporting of research findings, concerns over licensing processes for psychotropic drugs, and the mammoth investment of pharmaceutical companies in promoting anti-depressant medication as the panacea for treating depression (Breggin, 2008; Horwitz & Wakefield, 2007; Medawar & Hardon, 2004; Rose, 2007).

While not advocating a blanket dismissal of the benefits of anti-depressant medication - for clearly there is therapeutic value in medications that may relieve distressing symptoms for many people - however, the manner in which we speak about and conceptualise medications for depression would appear to benefit from a certain amount of revision. When speaking about anti-depressant medication from within a 'disease- centred' paradigm, the underlying assumption is that psychotropic medications correct pre-existing biochemical abnormalities. Moncrieff and Cohen (2005) outline the potential utility of shifting to a 'drug centred' model where, "Drugs are seen to induce characteristic physiological and subjective states that may, or may not, be experienced as useful in certain social and interpersonal situations, including clinical situations" (p. 146).

If research and practice begin from a point that does not assume drug effects arise as a result of their influence on underlying conditions but instead from the effects of the particular drug itself, a significant shift occurs in the ideological messages imparted about the nature of the problem in question - in this case depression and distress. Medications have powerful physiological

effects and we should be concerned with issues of safety and efficacy. However, these do not occur independently of the illness experience; they are not distinct conditions. As social and cultural phenomena, medicines do impart powerful ideological messages, medicines carry meaning, they are, as Nichter and Vuckovic (1994) say,

“...vehicles of ideology’ that embody “subtle ideas about self, illness causality and responsibility, the meaning of sickness, and perceptions of entitlement. Assumptions about what is normal and desirable, which link the physical body to the social body and to the body politic are likewise signalled by the taking of medicines” (p. 1509-1510).

As we move through the next section that explores how the women make sense of ongoing distress, the importance of recognising the power of such discourses and the way they constrain women in their sense making becomes increasingly visible.

Section 2: Living with complexity: Continuing invisibilities.

The following section aims to explore how the women talk of their ongoing experiences of distress and depression. The following discussion aims to highlight aspects of the women's ongoing interpretive work that appear to be particularly powerful in their constructions of these experiences. I pay particular attention to the women's talk of accessing additional professional help through counselling services. I have chosen to focus on this aspect of their narratives for two reasons, first, for its importance in the ongoing interpretive work of the women, and secondly, to bring forward the often hidden assumptions within mainstream theorising around depression in psychology. These effectively buttress the already taken-for-granted discursive constructions around femininity and motherhood that featured so prominently in the women's accounts of becoming-depressed.

Before moving on to explore the women's talk of their engagement with counselling, and the understandings they garner from such experiences, it is important to briefly revisit and bring forward some of the most salient aspects of the women's narratives around becoming depressed and entering the professional help arena. In Chapter 3, we saw how the women constructed a contextualised account of their experiences of becoming depressed. Discursive constructions of the ‘good’ woman and the taken-for-granted nature of the day-to-day conditions of their lives generated a space where it was infinitely possible for the women to blame themselves for their distress. The construction of their distress as evidence of personal failing was in and of itself a

significant source of distress. Upon seeking medical professional help and being shown a new way of making sense of their distress, the women took up a biochemical explanation of depression and began using anti-depressant medication. This shift in construction offered the women some protection from moral judgement by locating the ‘problem’ as physical rather than personal or psychological. However, in taking up this diagnosis and treatment, the women find themselves in a difficult space. This space allows particular ways of speaking about distress, but disqualifies important aspects of their experience from consideration.

Within this space, the women talk about their ongoing experiences of distress. A biomedical diagnosis and the provision of treatment by medication have not provided a lasting or complete solution. They speak of the unchanged nature of the conditions of their lives, and the distress that continues to arise from within this increasingly complex context. Of course, it is unsurprising that little has changed; unchallenged assumptions within discursive constructions of femininity work alongside the power of this dominant story of depression to disqualify these same conditions from consideration. Sara described how, after treatment with anti-depressant medication, many people assumed everything should just carry on as before. She says, *“And this is the thing, people think that once you go on medication it’s all finished but it’s not”*. Kate spoke of how after some initial reduction of responsibilities everything *“just goes back to normal... and it all just starts again”*. Helen described how things had improved after some time on holiday but says things quickly return to ‘normal’, *“I get into that routine of doing the same old crap every day, getting up, getting the kids ready, doing housework, homework, on and on and on, every single day”*. The women also spoke of the frightening and unpredictable nature of these ongoing experiences. This occurs in a context where these day-to-day conditions are invisible as legitimate sources of distress, and where depression is seen as a discrete entity conceptualised as separate from the context in which it arises (Horwitz & Wakefield, 2005). It is unsurprising that the ‘symptoms’ of depression might be viewed, as Helen said, as appearing to *“come out of nowhere”*. She goes on to say, *“I don’t understand it, it can happen so quickly sometimes”*. While this woman spoke of her experiences as located within the day-to-day conditions of her life, that the ‘sudden’ appearance of distress could be attributable to these conditions was not something she considered as legitimate. Under these conditions it is not surprising these ‘symptoms’ were experienced as potentially frightening, unpredictable, and confusing. It is here, in this difficult space, with a need to make sense of ongoing, and often frightening and unpredictable distress that the women decide to seek additional help through counselling.

Difficult decisions. Entering the counselling arena is a potentially risky experience for the women. On one hand, the women identify the usefulness of someone to *“talk things over with.”* On the other hand, to acknowledge they are still experiencing distress, particularly distress arising within the taken-for-granted conditions of their lives, is to risk entering the moral minefield of personal blame and responsibility the women narrowly escaped with the proffered biochemical explanation. The women spoke of concerns of confidentiality and shame in accessing Mental Health and Counselling Services. They spoke of concerns their cars would be seen in the car park of the hospital based service and they spoke of the ‘shame’ they would feel if this were to happen. They spoke of concerns that confidentiality rules would not be adhered to and the problematic nature of this in a small provincial city – *“everyone knows everyone”*. They also spoke of the unpleasantness of the physical location of the counselling services saying this was indicative of the status of mental health. One woman says, *“...it’s the place, the environment, it’s an icky, horrid depressive little area, not like the other parts of the hospital. Why can’t they have a nice sunny, yellow, friendly place for people to go and talk to someone. You know – but as well as that it’s just the name of the place means you’re nuts, you’re nuts and you need to go to a mental health clinic and you’re unstable...”*.

Researchers have long been exploring and theorising about the relationship between mental health, stigma, and seeking treatment. While this relationship remains unclear (Barney, Griffiths, Jorm, & Christensen, 2006; Mojtabai, 2008) we see illustrations in the women's talk of the concerns about how one is likely to be perceived if one takes on the mantle of mental illness. As an area for further research, exploring the women's experiences of stigma and seeking professional help would be a fruitful area of enquiry. It is interesting to note that the physical properties of the counselling environment was perceived by one woman as adding to the devaluated and discredited status of mental illness and highlights the manner in which material structures can inform discourse.

While the women express some ambivalence about entering the counselling arena, nearly all sought referrals to Community Mental Health Services from their GPs, or when finances allowed, accessed private counselling. It is of note that referral to Counselling Services was not routinely offered when the women initially sought help. Most of the women had to ask for referrals. In the instances where counselling was made available, it appears to be presented as an adjunct to medications, and to occupy a somewhat different position to the privileged SSRIs. Furthermore, while this shift into psychological services offers potential for exploring how other aspects of their lives might be implicated in their experience of distress, these services are still primarily located within medicalised settings that adhere to mainstream formulations of

depression as a disorder residing in the individual. We see this in the expectation from counsellors, whether private or public, that the women continue to use anti-depressant medication. In addition, accessing Secondary Level Mental Health Services through the Public Health system requires the women to meet DSM-V criteria for a diagnosis of depression. Private Counsellors accessed, linked with publicly funded services such as Accident Compensation Corporation (ACC) Sensitive Claims Unit, and operated within this same medicalised setting. The location of counselling services within a medicalised service delivery system suggests it would be more accurate to describe the counselling arena as offering an additional rather than alternative layer of discursive resources. Many factors contribute to the way services are set up and delivered, and in-depth discussion of these is beyond the scope of this analysis. However, we see here a further example of the inherent ideological messages imparted, whether intended or not, regarding the nature of the 'problem'. We see this in the manner in which 'treatment' is spoken about, and the possibilities for action made available to those seeking help.

All but one of the women chose to access counselling services. Angela chose not to access counselling services due to what she described as "*...a complete lack of faith in the services here*". She also stated that she had concerns around confidentiality that she could not put aside. Regardless of these concerns, she said she would have found it useful to talk things over with someone. The women that did attend counselling described mixed reactions to this experience. While several factors are likely to contribute to this variability, the women's talk of counselling and the understandings they arrive at about the nature of their distress, reflect concerns raised by social constructionist and feminist writers regarding mainstream theorising about depression in psychology. This section of the analysis does not attempt to offer a critique of any individual counselling practice, rather it aims to bring forward some of the assumptions that surround depression within mainstream counselling practice and explores the implications these may have for women who seek professional help.

The following discussion and excerpts illustrate how narrow conceptualisations of gender, the social domain, and the continued focus on the individual work together to disqualify important aspects of the women's experience. Culturally sanctioned, dominant constructions of depression and the individual foster a medicalised and pathologising understanding of the women's distress. These effectively shut down avenues for positioning themselves and their experiences of distress in more empowering ways. The women's talk of depression and distress reflects their struggle to incorporate aspects of their experience grounded in the gendered conditions of their

lives – conditions that were ongoing and for the most part unchanged – into their explanatory models of depression.

Cautious attempts, the problem with language. The women describe cautious attempts to bring forward and explore the particularities of the gendered conditions at the centre of their experiences of depletion, demoralisation, and distress. When filtered through mainstream theoretical understandings of depression, the source of the problem becomes located within the individual women. Several women spoke of their ongoing sense of distress around feelings of being a “*bad mother*”, or of having failed to cope with the contextual complexity so evident in their narratives. Sara talks of speaking with a counsellor about these feelings in an attempt to gain some reassurance to the contrary. She says, “*I try to talk about feeling selfish and feeling like a bad mother...they tell you it’s not your fault. You know. They say, you can’t help it because you’re depressed. You expect to think ‘Oh yeah’ but you come out still feeling selfish. You try to self-talk but it doesn’t work, you still feel that way, so they are going to look at some cognitive stuff this time*”. Filtered through a medicalised lens and constructed as a symptom of depression, these experiences now generate a particular way of attending to the ‘problem’. Feeling like a ‘bad’ mother is recast as a cognitive distortion, and the meaning of the women's experience within the socio-political and cultural context is effectively lost. Kelly talks of how her sense of being a bad mother continues to be the most distressing aspect of her experience. She describes her attempts to talk about this in counselling as difficult, not only because of the shame attached to these feelings, but also due to her struggle to articulate what this means to her. Likewise, several women refer to their experiences of ambivalence and struggle in the context of mothering and their gendered lives; as Helen says, “*it’s so wrong to feel like that*”. Kelly talks of struggling through exhaustion and the huge changes in lifestyle, identity, and relationships that are inevitable when becoming a mother. She says, “*I never wanted to say how I felt because I didn’t want people to say I didn’t love him coz I did. It’s such a massive part of your identity and I couldn’t split the two things up in my head, they didn’t fit – they don’t go together and you slam yourself for being a terrible human being and so much for being a terrible woman*”.

Becoming a mother and entering motherhood can be disruptive events in the lives of women; loss and grief are potential parts of this experience (Nicholson, 2003; Weaver & Ussher, 1997). The women's talk occurs in a socio-cultural environment that fails to recognise these aspects of experience as part of a natural change that occurs for some women in response to such dramatic and lifelong changes. At the same time, this same environment constructs motherhood as a ‘happy’ and ‘fulfilling’ period of one’s life. Several of the women spoke about the ‘wrongness’

of their feelings of loss and ambivalence. Helen said, *“When I was pregnant I remember feeling so worried that this baby was going to impact on my life so much that I’d regret having her, but not hate her... but I don’t know – that she would stop me doing the things I wanted to do. And now she does, and I get angry at her for that, and I shouldn’t. That is so wrong, mothers aren’t meant to feel like that, are they?”* Susan described how she felt when people would say to her, *“Oh you’ve got twins, how lovely, you must be so happy, and you’re thinking Oh God, what’s wrong with me, I’m not bloody coping. But the expectations, it kind of shuts you down”*.

In a context where to experience and/or disclose difficulties or ambivalence poses a risk to the moral identities so closely linked with motherhood and femininity (McCarthy, Edwards, & Eillies, 2000, as cited in Miller, 2005), the potential gap between ideology and lived experience can be at once bewildering and difficult to voice (Miller, 2005). Kirmayer (2005) highlights how, while a person’s inner world is constructed through discursive practices in the social world, there exists a gap between experience and expression. He suggests experience may not be expressed for a number of reasons; if it is emotionally difficult to do so, if there is a lack of appropriate language for articulating these experiences, if they do not fit within culturally sanctioned models, or if there is fear of negative reactions. In addition, DeVault (1990) highlights how when women are faced with inadequate language for articulating and giving meaning to their experiences, they are forced to say things that are not quite right, or to translate their meaning. In a context where depressive experiences are viewed through a medicalised lens, and where women experience difficulty bringing forward these aspects of experience, it is unsurprising that important parts of their experience can be lost and/or misunderstood. We see this further reflected in Helen’s talk of her attempts to talk about what she saw as the most important aspect of her depression experience, she says, *“I wanted to talk about my need to have things perfect, to make things perfect for everyone. Is that a true condition, could you label it, coz I have thought about this and it affects everything; it affects my family. There is so much pressure – always thinking I should do this and I just can’t – it’s too much”*. She returned to this several times throughout her narrative. She spoke of the frustration she felt as she attempted to explore, with both psychiatrist and psychologist, where this fitted into her depression experience. She spoke of how annoyed she felt, saying, *“What he saw, and what I saw were two different things”*. She described this as continuing to be the most ongoing, distressing aspect of her life, yet she was unable to see any way of reconciling this with her understanding of depression. She eventually concluded, *“...they must be two different things, how can a lack of serotonin make you feel like everything has to be perfect – it doesn’t fit – I don’t understand at all”*. In each of these excerpts, we see the women’s attempts to bring

forward the distress that arises as they try to live up to the ‘good woman’ image at the cost of their physical and emotional well-being.

A growing body of literature highlights the importance of these discursive conditions in women’s depression experiences. These excerpts highlight how easily these contextual meanings can be lost when filtered through mainstream formulations that begin with the woman as the site of pathology. Without adequate language, or recognition of social constructionist and feminist understandings within mainstream treatment practices, these women find they are misheard; their experiences reframed in individualistic notions resulting in self-blame and ongoing distress.

The trouble with symptoms. The focus on symptom management evident throughout the women’s narratives illustrates this focus on the individual, and a narrow conceptualisation of gender. While offering potentially useful strategies to the women for reducing symptoms of anxiety and distress, this focus on symptoms at the expense of contextualised understandings clearly imparts implicit statements about the nature of the problem. First, it arises within a medicalised understanding that privileges objectivity over subjectivity, where the experience and phenomenology of distress is reduced to symptom-based measures of an underlying disorder or evidence of depressogenic personality traits (Stoppard, 2000). Kirmayer (2005) also points to the inherent problems that arise when recovery is based on symptom reduction, reminding us of the cultural basis of symptom reporting and construction. When we reduce the experience of depression to its core features/symptoms we see a stripping down of the idiosyncratic illness experience. This focus on measurement and management of symptoms by its very nature reifies depression as a disorder and is an example of the power of discursive practices to produce the objects of which they speak (Foucault, 1972).

The inherent message in efforts to reduce symptoms in order to execute a return to a ‘previous non-symptomatic state’ resonates in statements such as “*I want to be fixed*” and “*I just want to be cured*”. The assertion is that one finds the conditions of their lives miserable because they are depressed, and this will be relieved if one targets the symptoms of depression. That one might be depressed due to the demands involved in managing the contextual complexity of their lives, which at the same time deplete the finite resources of the material body, is not readily entertained. At the same time, important aspects of the women’s subjective experience are missed, and can lead to blaming one’s self (or being seen as not trying hard enough) for ‘failing’ to instigate proposed lifestyle changes. Strategies such as attending to sleep needs, increased self-care, exercise, and leisure time (strategies suggested to the women) appear to be reasonable and useful activities for reducing distressing symptoms. However, they rest on assumptions that

individuals are autonomous beings and thus able to adopt such changes if they choose. This fails to take into account the gendered nature of women's lives. Recent studies into sleep and gendered work-family responsibilities highlight the difficulties women face in this particular area of self-care. In studies with families with young children, women's sleep was found to be scheduled around gendered responsibilities as a parent and provider (Maume, Sebastian, & Bardo, 2010). They concluded that gendered work, family responsibilities, and the emotional labour involved in attending to the well-being of family members were crucial factors in determining women's sleep regimes. In addition, Strazdins and Broom (2004) highlight the cost to women's health of gender inequities in the emotion work undertaken by women in families with young children, work that is often invisible and devalued. The women's talk reflects how their sleep is regulated by unrelenting demands on their time and energy. They talk of the persistent practical demands of caring for and managing the needs of young families; and they talk of the emotional demands of attending to the psychological and emotional needs of partners and children. Angela talked of attending to her husband's need to debrief about his stressful day when he returned from work late at night. She said, *"I've already put in a full day but my husband needs to talk about finances and he's had a rough day, and well that's your job, but then I can't sleep coz I'm so worried about what's going to happen"*. Kate talks about how she curtailed other activities in her life so that she could keep up with the relentless demands on her time at home and at work. She says, *"I sometimes think, what is 2 days off? All I've done is fold washing, tidy, and just manage to keep on top of things so the next week doesn't fall down. You know [husband's name] is a good bloke but he doesn't think of all the things you need to do, he's no substitute, he's not a woman"*. She later goes on to describe waking at night unable to breathe, believing she was having a heart attack. She describes this as brought on by high levels of anxiety about all the things she had to do and an overwhelming sense that she could not manage it all. Other women talk of broken sleep - night after night, of attending to the needs of young children, including those still breastfeeding. The relationship between fatigue, exhaustion, and depression is unclear, yet clearly, this relationship is crucial in understanding the experience of depression for these women. The demands of emotion work and sleep deprivation are aspects of the depression experience fundamental to the women's stories. As long as we continue to isolate domains of experience from one another, and disqualify crucial aspects of experience from consideration, these important pieces of the puzzle are missing. If we begin from a position that recognises the multi-layered and continuous reciprocal interaction between all domains of experience, we find that what appears to be 'dis-ordered', now seems a reasonable response to a complex contextual world; it makes sense.

Still remaining with the concept of self-care and symptom management - suggestions to increase leisure and self-care activities were perceived by the women as useful ideas but ones they found difficult to implement. Studies demonstrate that a women's complex sense of entitlement to leisure (Fullagar, 2008) and self-care, is a powerful constraint in implementing such strategies (LaFrance & Stoppard, 2006). Feelings of guilt and selfishness are common threads in the women's account of their ambivalence and struggle with self-care. While several of the women spoke of the benefits to their sense of well-being when they did engage in such activities, they also spoke of feeling selfish for putting their own needs ahead of others. The women appeared to experience what LaFrance and Stoppard (2006) termed a "discursive bind". The discursive backdrop, generated by discourses of femininity, rendered engagement in activities likely to be positive and health promoting as threatening to the 'good woman' identity that dominated the women's narratives. Angela talks of her struggle to self-care in a context that equates self-care with selfishness, she says, *"I have to recognise that I need to look after myself, even though my family is my priority. I still feel selfish, but I remind myself that I can't look after other people if I don't look after myself"*. She later says, *"I'm a sucker for helping people but I have to learn where to stop because if I don't look after me I can't look after anyone else"*. In this excerpt, Angela negotiates the discursive bind generated by the equating of self-care with selfishness, minimising the threat to her identity by the discursive linking of self-care with maintaining her ability to care for others. However, as LaFrance (2009) points out, while this may be a useful accounting strategy for facilitating self-care, it is important to explore the implications of such discursive devices. She suggests exploring other potentially more liberating accounting strategies less likely to maintain social constructions of femininity that give rise to this struggle in the first place.

Equally implicated in women's struggle to maintain self-care practices are the very real material constraints and demands on their time and energy. Susan talks of the benefits of swimming and taking time out, and she talks of the struggle to maintain these in the context of her day-to-day life. She says, *"I know I need to do them - I know they make me feel better because those are the strategies I put in place in [town name]. The counsellor said to me I had to go swimming every day; that things like exercise and food and anti-depressants would help. She was right they do help. I have to try my best to get on top of it but I have slipped back, moving in here with kids on my own and working, and everything that needs taking care of and I am so tired and run down"*. She concluded by saying she needed to try harder. Several of the women talked about the very real constraints they faced in attending to self-care. These included, but were not limited to, a lack of family support to help with child-care, financial difficulties and limitations in paying for babysitters, a lack of support from partners in domestic and child-care

activities, the demands of caring for sick and elderly relatives, and working full-time alongside household and childcare responsibilities. These material and discursive constraints are met with suggestions for improving time management skills, improving sleep hygiene, learning to say No, and taking more time out for fun, hobbies, and exercise. When this occurs at the expense of a fully contextualised understanding, the individualised discourse of personal inadequacy remains at the forefront (Gattuso et al., 2005).

A feature throughout all the women's narratives was repeated references to both the material constraints on their time and their sense that to prioritise precious time for them was to be selfish and unproductive. Drew and Paradise (1996) highlight the difficulties women with children experience in taking time to relax and maintain a 'healthy lifestyle', the adoption of which is constructed as a matter of personal choice and individual responsibility. This difficulty, they posit, arises within the very real material constraints of women's day-to-day lives. This struggle is compounded by a sense that an 'appropriate' and 'legitimate' use of one's time is where it is spent in activities related to mothering, paid work, housework and caring for others. To spend time on oneself is not perceived as a 'legitimate' use of time and is accompanied by feelings of guilt and selfishness.

It is clear from the above excerpts that in not attending to the particularities of an individual's material and discursive world, and not attending to the idiosyncratic meanings attached to such conditions, the particularities of that person's experience of depression are obscured. The possibilities for making sense of their experiences and for opening up spaces for resisting and negotiating material- discursive constraints are limited by such partial accounts. This highlights the importance of attending to the gendered dimensions of women's talk. Furthermore, it raises questions about how we might talk to women about utilising potentially useful strategies for reducing distress, without falling into the pitfalls of decontextualised and pathologising discourses.

Sadness entitlements. One of the concerns raised by social constructionist and feminist writers regarding mainstream theorising of depression in psychology is the limited conceptualisation of the social domain. These concerns focus on the separation of the social domain from other domains of experience, rendering the intricate and reciprocal relationship between domains invisible (Stoppard, 2000). Furthermore, mainstream theorising predominantly defines the social domain in terms of stress or adversity, conditions whose threat is primarily determined from the researcher's standpoint. A primary aim of such research is the identification of causal relationships between such events and depression, as such, this theorising falls short of a truly contextual understanding of women's experiences of depression.

Throughout the women's narratives, reference to the 'unremarkable' conditions of their lives, and the sense that somehow this excludes them from any culturally accepted, legitimate source of distress, forms a backdrop to their experiences. As a backdrop, this sense of "*having no right*" [to feel distressed] directly informs their ongoing appraisal of themselves as failing. While on the one hand, the biochemical explanation has offered a limited sense that they do have a reason for their distress - namely a biochemical reason - the social domain offers very little in the way of legitimacy for these women. When the 'unremarkable conditions' of their lives are not perceived as adequate to explain their ongoing distress, and they cannot point to 'unusual' and 'remarkable' sources of adversity or stress, the women are left with limited choices for legitimizing their experiences. Kate described her life and the demands she faced in managing the contextual complexity in her life, yet as she concluded, "*I don't have an explanation why this is happening. I have a neat marriage, two fabulous kids, neat friends, a nice place to live, and a job I love*". As with other women interviewed, even in a context where they were juggling significant demands on their time, and emotional and physical resources, without specific examples of remarkable and adverse events to account for their distress the women were unable to justify how they felt. In this 'unremarkable' context, to implicate the conditions of their lives as playing a role in their experience of depression, left the women open to seeing themselves, and being viewed by others, as "*self-absorbed*" and "*ungrateful*". It is within this context that Kate says, "*That's why the biochemical stuff makes sense to me*". It is unsurprising that in these circumstances the biochemical explanation continues to offer the most morally safe option for making sense, and for communicating their distress to others. Interestingly, Angela, who did not attend any form of counselling, spoke of the conditions of her life in ways that reflected a visibility not present in the other women's narratives. She did however clearly state that she would not communicate this contextual aspect of her explanatory model to others. Given the taken-for-granted and normalised nature of women's material and discursive worlds, she believed that if she were to implicate these conditions in her depressive experiences to others, this would be seen as evidence of her being depressed. Thus, when women do resist de-legitimising constructions of the complex contextual worlds they inhabit, the pervasive nature of these constructions may result in their continued silence and disconnection from important sources of support, whilst at the same time maintaining the status quo.

Points of resistance and power dynamics. Some of the women spoke of their resistance to attempts in the counselling arena to draw causal explanations between particular life experiences and their experiences of depression. These women clearly saw these causal links as "*far too simple*". Rebecca says, "*I wanted to look at who I was, not be put into a box.*"

You're treated as if we are all the same and what works for one woman is the answer". She goes on to say, "I went into counselling expecting to be fixed. I know that isn't what they do but I was surprised by the way they wanted me to come up with answers I didn't know or responses I didn't really feel. It was very formulaic. There were so many assumptions and when I resisted saying things about my past, he saw it as evidence that I was hiding things. I guess that's one of the reasons I stopped going". Another woman, Sara, said, "...they are always trying to find out where did it stem from, what's the thing in my past that's causing it, instead of looking at what's going on right now. I don't want to go over 35 years of history; I want to deal with now".

In highlighting the women's talk of such resistance, it is important to note that each of these women also spoke of the difficulty they had in bringing forward this resistance into the counselling arena. The positioning of the practitioner as expert and holder of knowledge had clear implications for how the women were able to talk about and manage this resistance. Sara spoke of her concerns about saying that she disagreed with her counsellor, or was unhappy with aspects of the treatment. She says, *"you don't want to upset the apple cart, you know, you don't want to complain because then they might, I don't know, you don't want them to go, 'Oh she's complained', and then treat me differently"*. To move outside the bounds of the passive, compliant patient in order to challenge aspects of her treatment was clearly not something Sara felt comfortable doing. Her discomfort highlights the power dynamics inherent in such settings. Several of the women spoke of the *"expert"* role of counsellors and physicians and of occasions where they awaited 'expert' answers as to the nature and cause of their problems. Several of the women's narratives had references to this power dynamic. Helen stated several times that she wanted to be *"cured"* - she said about counselling, *"that's their job, they are meant to fix you"*. Sara told me, *"I only ever want an answer at the end. I've always said to them, I just want you to fix me, that's all I want"*. Kelly talked of how she felt when her psychiatrist made notes about her history that left her feeling judged, she says, *"It made me so mad, it made it sound like I was this dreadful woman – the scarlet woman or something – then it's there written forever and there's nothing you can do about it"*. Rebecca said when speaking about her resistance to her counsellor's suggestion he invite the man that had sexually abused her to a counselling session so she could confront him, *"I said I don't, I don't, I don't want to do this, and he kept saying you've got to face him otherwise you can never take your power back. I kept telling him I didn't want to do it but he said I would never move on if I didn't do it. He didn't take my individual circumstances into account at all, he had this box that said sexual abuse victims must face their abusers to be able to move on. He's the expert and you start to think that's the only way. It was demoralising and demeaning, and it didn't make it any better"*.

This resistance to drawing links between specific earlier life events such as abuse, and later experiences of depression, reflects the women's sense that these are simplistic and partial explanations, unable to represent the complexity of their experiences. However, the women's initial response to drawing casual links between a biochemical imbalance and the depression experience, and their unwillingness to do the same in this instance, may in part be reflective of the different subject positions made available by these two very different conceptualisations. On the one hand, the biochemical explanation embedded in notions of objectivity and scientific 'truth' affords both moral protection and a means to address the problem - namely anti-depressant medication. On the other hand, issues like abuse still carry notions of individual blame and responsibility and thus lack the same moral protection. Coupled with a continued focus on the individual's psychological make-up, little attendance to the socio-political aspects of abuse, and with no readily or easily available means of attending to the problem, it is unsurprising this position offered little in the way of protection, hopefulness or relief.

Circular logic. The women's talk of counselling reflects the ongoing focus on the individual and recovery through symptom reduction but reveals very little in the way of gendered understandings. In a context where a focus on symptoms reifies depression as a disorder located in the individual, and this operates at the expense of a contextualised understanding, we see a striking illustration of the implications of this circular logic. It is in this context that the women talk of their struggle to determine what aspects of their distress are "valid", and what are not. Rebecca spoke of her constant appraisal of any distress she experienced, distress now known to her as symptoms of depression, as being fraught with an inability to work out whether she had "*a right to feel this way*". She says, "*You know, you're feeling all these things and you think, what's this all about. You can never figure it out – you know, is it valid, you don't even know if it's real? Is it because I'm depressed and I see things this way because of that. I don't know it's so hard to figure it out – I hate it*". Sara described how things had fallen back into "*the same old routine*". She recalls a period when her husband was working and spending weekends away with friends. She talks of the strain of caring for a relative with Alzheimer's, the ongoing struggles with her children, and a lack of help around the house. She says, "*It makes me so angry – come in from work, sit down on the couch, don't say hello or anything, while I've got the kids screaming and yelling and trying to organise dinner and it's all going mad – I just want a little bit of help. It makes me so angry and frustrated, but I don't want to say 'Look can you help me', because if I do it's like ohhhh - you get that negative response back*". She then goes on to conclude, "*It's probably me though, I perceive things and make them worse than they are, that's depression, that's what it does*". This way of accounting for distress - as arising from the disorder depression - rather than arising within the

normalised and taken-for-granted contextual complexity of their lives, was evident throughout all the women's narratives. The confusion and uncertainty generated was in and of itself an ongoing source of distress. When women find themselves overwhelmed by the complex interweaving of the material and discursive domains of their lives, and the result is increasing distress, they are encouraged to see this resistance/distress as a sign of internal pathology, rather than a credible and reasonable response to the conditions of their lives.

Ussher (2002) highlights how idealised versions of femininity construct the 'good woman' as one who is able to remain in control, and is unceasingly able to provide nurturing and care without complaint. When a women's behaviour falls outside these normative prescriptions - as in the above excerpts - dominant constructions of depression support positioning these experiences as arising from the disorder depression. As Sara said, *"I know that I've got depression because I cry a lot, crying, that's definitely a sign of depression"*.

A lack of alternative discursive resources. Where the women did draw links between certain situations and feelings of distress, ultimately the problem still lay within. Kate sums this up in her explanation of how she understands depression now. She says, *"It's like with brain injury, do you know much about that? It's where the threshold of someone's coping is reached and it brings forward the symptoms of brain injury"*. Here we see a further example of the positioning of one's responses to relentless demands on one's time and energy as arising from internal pathology. The very real effects on health and psychological well-being that arise in the context of ongoing responsibility and seemingly endless demands on one's time and material body are not legitimate in their own right. The use of the biochemical discourse offers legitimacy not available elsewhere. Kate speaks of her decision to remain on anti-depressant medication for life if she needs to, just as she would with any other organic disease. She also talks of understandings garnered through conversations with her GP, where research shows three episodes of depression indicate one should remain on anti-depressant medication indefinitely. Studies regarding long-term use of SSRIs are not available, and researchers raise concerns about the safety and long-term potential for neurochemical damage that extended use of SSRIs may have (Breggin, 2008). Another woman, Helen, told me she had arrived at the conclusion that her depression was biochemical and she would therefore remain on anti-depressant medication for the rest of life. She continued to talk of the ongoing distress in her life, clearly distress generated at the intersection of discourses and practices of femininity; yet, she saw no way of integrating these aspects of her life with a biochemical explanation. She concluded they must be two different things. She expressed her confusion and uncertainty about how to manage these irreconcilable aspects of her experiences. Clearly, she still had to

find ways to manage ongoing distress, yet the actions available to her were limited to the use of medication or Electro Convulsive Therapy (ECT). Despite very little involvement with alternative sources of help, Helen spoke of how following extensive surgery where she had been frightened about the possibility of permanent disability, she spoke with a psychiatrist. She says, *“He sat back in his chair – really felt like I was being judged, he asked me a bit about family history and said I could take this pill. He also said another option was ECT and he said cure, that’s all I heard was the possibility of a cure”*.

Other women adjusted their explanatory models to include aspects of their social world. These included the pressure of managing busy households while under financial pressure, and the isolation, fatigue and loneliness they experienced in managing the contextual complexity of their lives. However, the women continued to locate the source of the problem as their inability to either cope with these, as *“other women can”*, or as resulting from some sort of psychological deficit. Where the women did point to the pressure to live up to *“expectations”* of being a ‘good mother’ and ‘good woman’ as being unrealistic and unfair, they also condemned themselves for their inability to resist these pressures. Susan says, *“It’s my own fault, I know I shouldn’t worry about these things but I just can’t help it – I wish I wasn’t like that. It’s just too hard to let go of”*. Kelly said when speaking of how unrealistic expectations played a part in her experiences of depression, *“I still blame myself for that, I still try and figure out why coz it’s still there”*. The discursive bind discussed earlier, leaves the women walking a constant tightrope. Susan went on to say how she wished she could be normal. She says, *“I’m a pleaser - I really wish I could figure out why – you know feel that my feelings were valid like normal people, I wish I could put them into some sort of context, you know, so they make sense, but I can’t”*. Regardless of how the women adjusted their explanatory models to allow inclusion of these social aspects of their lives, nearly all the women remained on anti-depressant medication. The fragmentation and uncertainty that remains is reflected in one woman’s comment, *“I am going to try to wean myself off them, but it’s scary because I don’t really know if I feel better because of them or because of me”*.

Remaining vigilant. The women's accounting strategies now reflect some of the additional layers garnered through their experiences of counselling, understandings that continue to locate the source of the problem within. It is in this context the women spoke of the fear they had of returning to a deeply depressed state. Given the nature of the subjective experience of depression, this is of course not surprising. However, in their attempts to manage depression, the women were encouraged to monitor themselves and remain vigilant against an increase, or return of symptoms. In this context, where distress is conceptualised as symptoms of

depression, any expression of distress is filtered through this 'depression' lens. The women now view signs and symptoms of depression, signs and symptoms remarkably similar to those seen in instances of normal but intense sadness, (Horwitz & Wakefield 2007) as markers of the 'disorder depression'. They talk of the need to remain vigilant and to monitor themselves for signs that things are getting out of control. The resulting pathologisation of all instances of the women's sadness, demoralisation, and depletion of physical resources, represents a powerful form of self-surveillance (Foucault, 1979). The invisibility of the gendered conditions of their complex social and discursive worlds has come full circle.

Gordon (1988) highlights two categories of "tenacious assumptions" central in Western medicine. The first of these relates to nature/biology as autonomous from human consciousness; a realm separate from morality and society. The second tenacious assumption relates to the individual as an autonomous and distinct being, separate from, and prior to society and culture. We see these assumptions reflected throughout the women's talk of seeking professional help - from the medicalisation of their distress as they seek help and receive a diagnosis, to their talk of counselling and their understandings of depression as a disorder. As we move through their stories, we find important aspects of their experience obscured, disqualified, or rendered invisible. The story of depression is a complex one and this analysis has touched only aspects of that story. I have attempted to make explicit some of the hidden processes/aspects of this embodied complexity and explore how current dominant discourses of depression and SSRIs work alongside discursive constructions of femininity to achieve this invisibility. When we attend to the women's stories of their depressive experiences, the material-discursive conditions that shape and regulate their lives are at the forefront of their narratives. Just as Galasinski (2008) stated in his work with men who had experienced depression, "...there is no depression outside the dominant model of masculinity" (p171); whatever else it may be, for these women depression was, and is, a profoundly gendered experience.

Chapter 6: Conclusions

In this exploration of women's talk of depression and entering the professional-help arena two main areas come forward as pivotal features of the women's stories. First, the women's accounts are highly gendered; participants consistently locate their distress and depressive experiences within the context of their lives as women. Secondly, immediately upon entering the professional help arena the women's experiences of distress are medicalised. This is a significant turning point in their interpretive journeys.

The women's talk centres on the distress generated at the intersection of discourses and practices of femininity. The often unsustainable nature of living up to cultural expectations of what it means to be a 'good' woman/mother within the confines of the finite resources of the material body are central to their stories. The women's accounts highlight the interplay between taken-for-granted and narrow discursive constructions of the 'good' woman/mother, and material aspects of experience, including the gendered body. The resulting production of distress and the construction of one's self as personally flawed is an inevitable outcome of limited ways outside the confines of discourse of femininity, for making sense of one's embodied experiences in meaningful and socially acceptable ways.

The women's account of their professional help seeking experiences reflect how contemporary constructions of depression as a medicalised disorder serves as a filter for their experiences. Prior to entering the professional help arena, the women do not see their distress as arising from a mental disorder, nor do they label their experiences as depression. Upon entering the professional help arena, the set of complex responses located in the conditions of their lives is conceptualised as a mental disorder with a biological base. This operates as a double-edged sword. It offers a way for the women to shift blame from their character to their brain serving as protection against threats to their identities as women. At the same time, it renders important and fundamental aspects of their experience invisible. Medicalised explanations of the women's distress buttress unchallenged and taken-for-granted discursive constructions of femininity to render the context of their day-to-day lives invisible as legitimate sources of distress. This effectively does little to challenge the status quo and leaves women with limited discursive resources for talking about their distress.

The women's experiences of using anti-depressant medications centre primarily on constructions of safety and efficacy. Offering at times only limited benefits for reducing distress, and having the potential for significant harm, the women's commitment to using anti-

depressant medication in part reflects their struggle to legitimise their experiences outside of a medicalised framework. The women find themselves with the choice of situating their distress within the conditions of their lives thus reinforcing notions of inadequacy and 'not coping', or attributing their distress to biochemical and/or psychological dysfunction. If the women do locate their experiences of distress within the conditions of their lives they find themselves surrounded by cultural constructions of the 'stoic' individual who copes alone, leaving them few means with which to address their distress.

The medicalisation of their distress and treatment with anti-depressant medication marks a significant turning point in the women's depression trajectories and highlights how important diagnosis can be in an individual's sense-making process. Information offered to the women around safety and efficacy of anti-depressant medication is critical to their decision to pursue this line of treatment. The women's talk of using medication reflects these highly controversial constructions around anti-depressant medication. This raises ethical questions with regard to the use of medications and subsequent monitoring of their use. Given the controversy surrounding anti-depressant medication and increasing concerns around safety and efficacy, what at times appears to be their unmitigated use, would appear to need tempering with a significant measure of caution.

One of the consequences of limiting and pathologising individualised constructions of depression may well be the continued high representation of women in mental health statistics. As long as women are encouraged to locate the source of their distress within themselves - whether the conceptualisation is psychological or biochemical - we may see little change in the chronicity of this disorder. Constructions of depression as a recurring disorder, alongside the absence of socially acceptable and meaningful ways of making sense, has the potential to prolong experiences of distress. In addition, when women are encouraged to monitor themselves for symptoms of depression shorn of their social-cultural context, women are likely to interpret all instances of distress as signs of depression. Not only does this serve to maintain the status quo with regard to the conditions of their lives, conditions consistently implicated in the production of distress, it also reinforces notions of personal blame/flaw. This has the potential to add significantly to ongoing experiences of distress and constructions of the self as deficient.

When women have their experiences medicalised, and these individualised conceptualisations are the most readily available and culturally acceptable way of talking about depression, the possibility of generating alternative and meaningful discursive resources for speaking about distress are limited. The more we privilege medicalised conceptualisation of distress, the more

difficult it is for women to find culturally acceptable ways of talking about distress that reflects the complexity of their depressive experiences. There is a worrying circularity to how we construct depression as a mental disorder and the constraints this imposes on our ability to conceive of depression outside of these constructions. The generation of new discursive resources for talking about mothering, femininity, and depression would seem to be paramount and this may be particularly important with regard to how we talk about, and think about, experiences collectively termed post-natal depression.

At a societal level, current strategies to increase mental health literacy focus on gender-neutral, medicalised understandings of depression with a focus on symptom identification. These have the potential to further broaden the reaches of a trend to pathologise normal but intense sadness and distress. What are undeniably in many cases highly distressing but understandable responses to the many vicissitudes of life, are increasingly likely to be interpreted as signs of mental disorder and treated accordingly. Increased use of anti-depressant medication both nationally and internationally already signals this profound shift in the way we think about distress and depression (Rose, 2006). Continued efforts to streamline and be more precise in the way we identify and treat depression have already taken on significance in research funding around depression (WHO, 2001). While these may be important, they effectively shift the focus of policy away from addressing the social and economic context so profoundly implicated in women's talk of depression.

While this study takes as its focus, only a small number of women from a rural area, it does offer consistent support for previous qualitative research that has women experiences of depression as its focus. This suggests that the findings of this study may be reflective of women's experiences at large. It would however, be interesting to look at women's experience of depression in larger cities, ones that are likely to have a broader range of options for treatment and where GPs may not be the only or first port of call for seeking professional help. This study does however, offer additional insight into women's depression experiences by exploring women's accounts as an unfolding process that is heavily contextually dependent. These accounts are located in a social context that often assumes discourses of femininity are no longer relevant in the shaping of experience for women, a post feminist age. In addition, these accounts are also located in a never before seen social and cultural context where depression as viewed as a worldwide epidemic and responded to accordingly. One of the strengths of this study lies in the reminder it serves of the need to broaden our research focus to include women's experiences of depression and seeking help. Furthermore these findings illustrate the power discourse has in shaping and constraining subjectivity. Depression is a subjective experience,

with diagnosis relying, unlike physical disease, primarily on subjective accounts. Distorting women's experiences to fit preconceived notions of mental disorder has long lasting and serious implications for the women's sense making processes and highlights the need to foreground women's experiences in theorising about and treating depression. Should we continue to privilege narrow, conceptualisations of depression that focus on the individual ignoring the gendered dimensions of depression, women are likely to continue to be represented in depression statistics at alarmingly high rates.

References

- Bamberg, M. & Andrews, M. (2004) *Considering counter-narratives: Narrating, resisting, making sense*. Amsterdam: John Benjamins Publishing.
- Barney, L. J., Griffiths, K. M., Jorm, A. F., & Christensen, H. (2006). Stigma about depression and its impact on help-seeking intentions. *Australian and New Zealand Journal of Psychiatry*, 40(1), 51-54, doi:10.1111/j.1440-1614.2006.01741.x
- Breggin, P. R. (2008) *Brain-disabling treatments in psychiatry: Drugs, electroshock, and the psychopharmaceutical complex* (2nd ed.) New York: Springer Publishing Company.
- Breggin, P. R., & Breggin, G. R. (1994) *Talking back to Prozac. What doctors won't tell you about today's most controversial drug*. New York: St Martin's Press.
- Bromet, E., Andrade, L., Hwang, I., Sampson, N., Alonso, J., de Girolamo, G., (...), Kessler, R.C. (2011). Cross-national epidemiology of DSM-IV major depressive episode. *BMC Medicine*, 9(1), 90, doi: 10.1186/1741-7015-9-90
- Brown, K., & Augusta-Scott, T. (2007). (Eds.). *Narrative therapy. Making meaning, making lives*. Thousand Oaks, CA: Sage.
- Bschor, T., & Baethge, C. (2010). No evidence for switching the antidepressant: systematic review and meta-analysis of RCTs of a common therapeutic strategy. *Acta Psychiatrica Scandinavica*, 121(3), 174-179, doi: 10.1111/j.1600-0447.2009.01458.x.
- Burr, V. (2003) *Social constructionism* (2nd ed.) London: Routledge.
- Caplan, P., & Cosgrove, L. (2004) *Bias in psychiatric diagnosis*. Lanham: Jason Aronson.
- Chisholm, D. (2011) Woe be gone. *North and South*, 76.
- Clarke, J. & Gawley, A. (2009) The triumph of pharmaceuticals: The portrayal of depression from 1980-2005. *Administration and Policy in Mental Health*, 36, 91-101, doi:10.1007/s10488/0880199-2.
- Cohen, D., McCubbin, M., Collin, J., & Pérodeau, G. (2001). Medications as social phenomena. *Health*, 5(4), 441-469, doi: 10.1177/136345930100500403.

- Cohen, D. (2004) Needed: critical thinking about psychiatric medications. *Keynote Address: 4th International Conference on Social Work in Health and Mental Health, Quebec City*, retrieved from < www.ahrp.org/about/CohenPsychMed0504.pdf.
- Conrad, P. (1992). Medicalization and social control. *Annual Review of Sociology*, 18, 209-232, retrieved from < www.jstor.org/stable/2083452.
- Cosgrove, P. (2000) Crying out loud: Understanding women's emotional distress as both lived experience and social construction. *Feminism and Psychology* 10, 247-267, doi: 10.1177/0959353500010002004.
- Currie, J. (2005). The marketization of depression: The prescribing of SSRI antidepressants to women. Toronto: Women and Health Protection, retrieved from <www.psychrights.org/Articles/SSRIs.pdf.
- Davies, B., & Harré, R. (1990). Positioning: The discursive production of selves. *Journal for the Theory of Social Behaviour*, 20(1), 43-63, doi: 10.1111/j.1468-5914.1990.tb00174.x.
- Devault, M. (1990) Talking and listening from women's standpoint: Feminist strategies for interviewing and analysis. *Social Problems*, 37 (1) 96-116, retrieved from < www.jstor.org.ezproxy.massey.ac.nz/stable/800797.
- Double, D. (2002). The limits of psychiatry. *British Medical Journal* 324, 900-4.
- Drew, S., & Paradice, R. (1996). Time, women, and well-being. *Feminism & Psychology*, 6(4), 563-568, doi: 10.1177/0959353596064017.
- Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science* 196, 129-136.
- Figert, A. E. (1995). The three faces of PMS: The professional, gendered, and scientific structuring of a psychiatric disorder. *Social Problems*, 42(1), 56-73, retrieved from < www.jstor.org/stable/3090075.
- Foucault, M (1972). *The archaeology of knowledge*. London: Tavistock.
- Foucault, M. (1973). *The birth of the clinic: An archaeology of medical perception*. London: Tavistock.

- Foucault, M. (1979) *The history of sexuality: An introduction*. New York: Vintage Books.
- Fullagar, S. (2008). Leisure practices as counter-depressants: Emotion-work and emotion-play within women's recovery from depression. *Leisure Sciences*, 30(1), 35-52, doi: 10.1080/01490400701756345.
- Galasinski, D. (2008) *Men's discourses of depression*. New York: Palgrave McMillan.
- Gardner, P. (2003). Distorted packaging: Marketing depression as illness, drugs as cure. *Journal of Medical Humanities*, 24(1/2), doi:10.1023/A:10213114017235.
- Gattuso, S., Fullagar, S., & Young, I. (2005). Speaking of women's 'nameless misery': The everyday construction of depression in Australian women's magazines. *Social Science & Medicine*, 61(8), 1640-1648, doi:10.1016/j.socscimed.2005.03.020.
- Gordon, D. R. (1988) Tenacious assumptions in western medicine, In M. Lock & D. Gordon (Eds.) *Biomedicine Examined*, (pp. 19-56), Dordrecht, Holland: Kluwer Academic Publishers.
- Greenberg, G. (2010) *Manufacturing depression. The secret history of a modern disease*. New York: Simon and Schuster.
- Guba, E., & Lincoln, Y. (Eds.). *Handbook of qualitative research*. Thousand Oaks, CA: Sage.
- Harré, R. & Van Lagenhove, L. (Eds.) (1998) *Positioning theory: Moral contexts of intentional action*. Oxford: Blackwell Publishers.
- Healy, D. (1997) *The antidepressant era*. Cambridge, MA: Harvard University Press.
- Healey, P. (2010). DSM diagnosis and beyond: On the need for a hermeneutically-informed biopsychosocial framework. *Medicine, Health Care and Philosophy*, 14(2) 163-75, doi: 10.1007/s11019-010-9284-x.
- Hirshbein, Laura. D. (2006). Science, gender, and the emergence of depression in American psychiatry, 1952-1980. *Journal of the History of Medicine and the Allied Sciences*, 61(2), 187-226, doi: 10.1093/jhmas/jrj037.
- Horwitz, A. V. & Wakefield, J. C. (2007) *The loss of sadness: How psychiatry transformed normal sorrow into depressive disorder*. New York: Oxford University Press.

- Hwang, W-C, Myers, H.F., Abe-Kim, J., & Ting, J.Y. (2008) A conceptual paradigm for understanding culture's impact on mental health: The cultural influences on mental health (CIMH) model. *Clinical Psychology Review*, 28, 211-227.
- Illich, I. (2003). Medical nemesis. *Journal of Epidemiology and Community Health*, 57(12), 919-922, doi: 10.1136/jech.57.12.919.
- Jack, D. C. (1991) *Silencing the self: Women and depression*. Cambridge, MA: Harvard University Press.
- Karp, D. A. (1996) *Speaking of sadness: Depression, disconnection and the meaning of illness*. New York: Oxford University Press.
- Kirk, S., & Kutchins, H. (1992) *The selling of dsm: The rhetoric of science in psychiatry*. New York: A. De Gruyter.
- Kirmayer, L. J. (2005). Culture, context and experience in psychiatric diagnosis. *Psychopathology*, 38, 192-96.
- Kirmayer, L. J. (2006). Beyond the 'new cross-cultural psychiatry': Cultural biology, discursive psychology and the ironies of globalization. *Transcultural Psychiatry*, 43(1), 126-144, doi: 10.1177/1363461506061761.
- Kramer, P. D. (2005) *Against depression*. New York: Viking.
- LaFrance, M. N. (2007) A bitter pill: A discursive analysis of women's medicalised accounts of depression, *Journal of Health Psychology*, 12(1), 127-40, doi: 10.1177/1359105307071746.
- LaFrance, M. N. (2009). *Women and depression; Recovery and Resistance*. New York: Routledge.
- LaFrance, M. N., & Stoppard, J. M. (2006). Constructing a non-depressed self: Women's accounts of recovery from depression. *Feminism & Psychology*, 16(3), 307-325, doi: 10.1177/0959353506067849.
- Lewis, B. (2006). Listening to Chekhov: Narrative approaches to depression. *Literature and Medicine*, 25(1), 46-71, doi:10.1353/lm.2006.0023.

- Lewis, S. E. (1995). A search for meaning: Making sense of depression. *Journal of Mental Health*, 4(4), 369-382, doi: 10.1080/09638239550037424.
- Link, B. G. (1987). Understanding labeling effects in the area of mental disorders: An assessment of the effects of expectations of rejection. *American Sociological Review*, 52(1), 96-112, retrieved from < www.jstor.org/stable/2095395.
- Link, B.G., & Phelan, J.C. (2001) Conceptualising stigma. *Annual Review of Sociology*, 27, 363-385, doi: 10.1146/annurev.soc.27.1.363.
- Link, B. G., Cullen, F. T., Struening, E., Shrout, P. E., & Dohrenwend, B. P. (1989). A modified labeling theory approach to mental disorders: An empirical assessment. *American Sociological Review*, 54(3), 400-423, retrieved from < www.jstor.org/stable/2095613.
- Marecek, J. (2006). Social suffering, gender, and women's depression, In C.L. Keyes and S.H. Goodman (Eds.), *Women and depression: A handbook for the social, behavioural, and biomedical sciences*, pp. 283-308, Cambridge: Cambridge University Press.
- Mathers, C., Fat, D.M., Organisation, W.H., & Boerma, J.T. (2008). The global burden of disease: 2004 update: *World Health Organisation*, retrieved from <www.who.int/healthinfo/global_burden_disease/2004_report_update/en/index.html.
- Maume, D. J., Sebastian, R. A., & Bardo, A. R. (2010). Gender, work-family responsibilities, and sleep. *Gender & Society*, 24(6), 746-768, doi: 10. 1177/0891243210386949.
- Mauthner, N. S. (1998). 'It's a woman's cry for help': A relational perspective on postnatal depression. *Feminism & Psychology*, 8(3), 325-355, doi: 10.1177/09593598083006.
- Mauthner, N. (1992) *The darkest days of my life: Stories of postpartum depression*. Cambridge: Harvard University Press.
- Medawar, C. (1997) The antidepressant web: marketing depression and making medicines work. *International Journal of Risk & Safety in Medicine*, 10 (2), 75-126.
- Medawar, C. & Hardon, A. (2004) *Medicines out of control: Antidepressants and the conspiracy of goodwill*. Aksant Academic Publishers.

- Metzl, J. M. & Angel, J. (2004) Assessing the impact of SSRI antidepressants on popular notions of women's depressive illness. *Social Science and Medicine*, 58: 577-584, doi: 10.1016/S0277-9536(03)00369-1.
- Mirowsky, John., & Ross, Catherine. E. (1989). Psychiatric diagnosis as reified measurement. *Journal of Health and Social Behaviour*, 30(1), 11-25. American Sociological Association, retrieved from <www.jstor.org/stable/2136907.
- Miller, T. (2005) *Making sense of motherhood: A narrative approach*. Cambridge: University Press.
- Mills, S. (1997). *Discourse*. London: Routledge.
- Mojtabai, R. (2010). Mental illness stigma and willingness to seek mental health care in the European Union. *Social Psychiatry and Psychiatric Epidemiology*, 45(7), 705-712, doi:10.1007/s00127-009-0109-2.
- Moncrieff, J. & Cohen, D. (2005) Rethinking models of psychotropic drug action. *Psychotherapy and Psychosomatics*, 74:145-153, doi: 10.1159/000083999.
- Moynihan, R., Health, I., & Henry, D. (2002) Selling sickness: the pharmaceutical industry and disease mongering. *British Medical Journal*, 324, 886-891, doi: 10.1136/bmj.324.7342.886.
- Nichter, M. & Vuckovic, N. (1994) Agenda for an anthropology of pharmaceutical practice. *Social science Medicine*, 39, 1509-1525, doi: 10.1061/0277-9536(94)90003-5.
- Nicolson, P. (1991) Explanations of post-natal depression: Structuring knowledge of female psychology. *Research on Language and Social interaction*, 25, 75-96.
- Nicolson, P. (1998) *Post-natal depression: Psychology science and the transition to motherhood*. New York: Routledge.
- Nicolson, P. (2003) Postpartum Depression: Women's accounts of loss and change. In J. Stoppard & L. M. McMullen (Eds.) *Situating sadness: Women and depression in social context*. (pp. 113-138). New York: University Press.

- Outram, S., Murphy, B., & Cockburn, J. (2004). Factors associated with accessing professional help for psychological distress in midlife Australian women. *Journal of Mental Health*, 13(2), 185-195, doi: 10.1080/09638230410001669336.
- Parker, I. (1992). *Discourse dynamics: Critical analysis for social and individual psychology*. London: Routledge.
- Parker, I. (1994). Reflexive research and the grounding of analysis: Social psychology and the psy-complex. *Journal of Community & Applied Social Psychology*, 4(4), 239-252, doi: 10.1002/casp.2450040404.
- Pilgram, D. & Bentall, R. (1999) The medicalisation of misery: A critical realist analysis of the concept of depression. *Journal of Mental Health*, 8 (3), 261-274, doi: 10.1080/09638239917427.
- Riessman, C. (1992) Women and medicalisation: A new perspective. In G. Kirkup & L. S. Keller (Eds.) *Inventing women: science, technology, and gender* (pp. 123-144). UK: Polity Press.
- Rose, N. (2003). Neurochemical selves. *Society*, 41(1), 46-59.
- Rose, N. (2006). Disorders without borders? The expanding scope of psychiatric practice. *BioSocieties*, 1(04), 465-484, doi: 10.1017/S1745855206004078.
- Rose, N. (2007) *The politics of life itself: Biomedicine, power, and subjectivity in the twenty-first century*. Princeton: Princeton University Press.
- Schomerus, G., & Angermeyer, M. C. (2008). Stigma and its impact on help-seeking for mental disorders: what do we know? *Epidemiologia e psichiatria sociale*, 17(1), 31-37.
- Schomerus, G., Matschinger, H., & Angermeyer, M. (2009). The stigma of psychiatric treatment and help-seeking intentions for depression. *European Archives of Psychiatry and Clinical Neuroscience*, 259(5), 298-306, doi: 10.1007/s00406-009-0870-y.
- Schreiber, R., & Hartrick, G. (2002). Keeping it together: How women use the biomedical explanatory model to manage the stigma of depression. *Issues in Mental Health Nursing*, 23(2), 91-105, doi: 10.1080/0161284027535427969.

- Shorter, E. (1997). *A history of psychiatry: From the era of the asylum to the age of Prozac*. Oxford, UK: Wiley.
- Stoppard, J. (1997) Women's bodies, women's lives, and depression: Toward a reconciliation of material and discursive accounts. In J. M. Ussher (Ed.), *Body talk: The material and discursive regulation of sexuality, madness and reproduction* (pp. 10-32). London, UK: Routledge.
- Stoppard, J. M. (1998). Dis-ordering depression in women. *Theory & Psychology*, 8(1), 79-99, doi: 10.1177/0959354398081005.
- Stoppard, J. (2000) *Understanding depression. Feminist social constructionist approaches*. London: Routledge.
- Stoppard, J. & McMullen, L. M. (Eds.) (2003) *Situating sadness: Women and depression in social context*. New York: University Press.
- Strazdins, L., & Broom, D. H. (2004) Acts of love (and work) : Gender imbalance in emotional work and women's psychological distress. *Journal of Family Issues*, 25, 356-378, doi: 10.1177/0192513X03257413.
- Thomas-McLean, R. & Stoppard, J. (2004) Physicians' constructions of depression: Inside/outside the boundaries of medicalization. *Health (London)* 8, 275-293.
- Ussher, J. M. (1991) *Women's madness: Misogyny or mental illness?* Amherst, MA: University of Massachusetts Press.
- Ussher, J. M. (2002). Processes of appraisal and coping in the development and maintenance of Premenstrual Dysphoric Disorder. *Journal of Community & Applied Social Psychology*, 12(5), 309-322, doi: 10.1002/casp.685.
- Ussher, J. M. (2010) Are we medicalising women's misery? A critical review of women's higher rates of reported depression. *Feminism Psychology*, 20(9), doi: 10.1177/0959353509350213.
- Van der Geest, S., Whyte, S. R., & Hardon, A. (1996) The anthropology of pharmaceuticals: A biographical approach. *Annual Review of Anthropology*, 25, 153-178, retrieved from <www.jstor.org/stable/21555822>.

- Weaver, J. J., & Ussher, J. M. (1997). How motherhood changes life: A discourse analytic study with mothers of young children. *Journal of Reproductive and Infant Psychology*, 15(1), 51-68, doi: 10.1080/12646839708404533.
- Wells, E. J., Oakley Browne, M. A., Scott, K. M., McGee, M. A., Baxter, J., and Kokaua, J. (2006) Te Rau Hinengaro: The New Zealand Mental Health Survey: An overview of methods and findings. *The Australian and New Zealand Journal of Psychiatry*, 40(10), 835-844, doi: 10.1111/j.1440-1614.2006.01902.x.
- Willig, C. (1998) *Applied discourse analysis: Social and psychological interventions*. Buckingham: Open University Press.
- Willig, C. (2000) A discourse dynamic approach to the study of subjectivity in health psychology. *Theory Psychology*, 10, 547-570, doi: 10.1177/0959354300104006.
- Willig, C. (2008) *Introducing Qualitative research in Psychology* (2nd ed.). Open University Press: McGraw-Hill Education.
- Wittink, M. N., Dahlberg, B., Biruk, C., & Barg, F. K. (2008) How older adults combine medical and experiential notions of depression. *Qualitative Health Research*, 18, 1174-1183, doi: 10.1177/1049732308321737.
- World Health Organization (WHO) (2001). *The world health report 2001 - Mental health: new understanding, new hope*, Geneva: World Health Organization, retrieved from <www.who.int/whr/2001/en/index.html>.
- Yardley, L. (1996) Reconciling discursive and materialist perspectives on health and illness: A reconstruction of the biopsychosocial approach. *Theory and Psychology*, 6, 485-508, doi: 10.1177/0959354396063008.
- Yardley, L. (Ed.) (1997) *Material discourses of health and illness*. London: Routledge.

Appendices

Appendix 1: Information Sheet

(Massey University letterhead)

Women's Experience of Depression and Professional Help Seeking.

My name is Jodie Batten and I am currently a full time student in the Master of Arts Psychology degree at Massey University, Albany. I am conducting a research project under the supervision of Professor Kerry Chamberlain as part of my degree requirements. My project aims to explore women's experience of depression and seeking professional help. I am interested in hearing about your stories of depression and how you made sense of what was happening in your life. I am also interested in your experiences of seeking professional help for this; what your expectations were and what sort of help you received.

Who can take part?

I would like to interview you if you have used the word depression to name what you have experienced and have sought professional help for this in the past 2 years. This may have been through your GP, counseling or Mental Health Services. You need only have attended once or you may have had ongoing contact. You would need to be over 18 years of age. You will have completed any treatment you may have been involved in **or** are engaged with your GP or counsellor for general support.

I recognize that talking about your experiences may not be easy and I will do everything I can to make sure that this is a safe, respectful, and hopefully, interesting experience for you. I would value the opportunity to talk with you about your experiences and as compensation for the time and energy you would be contributing, participants will be given a \$30.00 voucher for Paper Plus or petrol.

If you know anyone else you think might be interested in participating, please ask them to contact me and I will provide them with an information sheet. Please be assured that by contacting me you are not agreeing to participate, but are merely expressing interest.

What would be required of me if I decide to participate?

You would need to take part in an interview that would last about 1-1/2 hours. The interview would be audio taped and transcribed by me. When and where the interview will happen would

be decided on in collaboration with you, and may be in your own home or somewhere else you think you would feel comfortable talking about this. You can ask questions and clarify any issues you may have about the project at any time, and can withdraw your participation up to one week after the completion of the interview. During the interview, you do not need to answer anything you don't want to and can have the tape recorder turned off at any time.

How will your information be used?

All information provided by you will be treated confidentially and only my supervisor and I will have access to the transcripts of our conversation. The information you provide will be used solely for this study. Your contact details and consent form will be stored separately at Massey University to protect your confidentiality and I will be the only person who knows who you are. The audio-tapes will be destroyed as soon as the analysis is completed and the transcripts with all identifying information removed will be stored securely for a period of five years and then disposed of, as required by research protocols.

You can choose to have a summary of the findings sent to you at the end of the project. Please indicate on the Consent form if you would like this summary.

I am happy to answer any questions you may have and please feel free to contact my supervisor if you any questions about this project.

Professor Kerry Chamberlain

School of Psychology

Massey University

Private Bag 102 904

North Shore MSC

Auckland

Telephone: (09) 414 0800 ext. 41226

Email: K.Chamberlain@massey.ac.nz

Jodie Batten

1967 Waingake Road

RD 1, Manutuke

Gisborne 4078

Telephone: (06) 8629 844

Email: jodieandjason@clear.net.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application ___/___ (*insert application number*). If you have any concerns about the conduct of this research, please contact Dr Denise Wilson, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 ext. 9070, email humanethicsnorth@massey.ac.nz

On Massey Letterhead

Appendix 2 Consent Form.

Women's Experience of Depression and Professional Help-Seeking.

This consent form will be held for a period of Five (5) years.

I have read the information sheet provided and had the details of the study explained to me. I have had opportunity to ask questions and have had these answered to my satisfaction.

I would like to participate in the proposed study and be interviewed about my experiences of depression and professional help seeking. I understand that I can decline to answer any questions and stop the interview at any time.

I agree to participate in this study under the conditions outlined in the information sheet:

Full Name of Participant:

Signature: _____

Date: _____

I would like to be provided with a summary of the research findings. YES ____ NO ____

If you have requested a summary of the research findings, please provide contact information below:

EITHER: Your address:

OR: Your email address:
