

**The Social Construction of Depression:
Experience, Discourse and Subjectivity.**

VOLUME 1

by

Siân Elisabeth Lewis

Departments of Psychology and Psychiatry

Thesis submitted to the University of Sheffield in partial fulfilment of the degree of
Doctor of Philosophy

July 1995

The Social Construction of Depression: Experience, Discourse and Subjectivity.

by Siân Elisabeth Lewis

Summary

The thesis shifts the explanatory framework of depression from the currently predominant clinical model which explains depression as a problem located in the individual, to a social psychological approach which explains depression in terms of its meaning to the individual, as an experience of self, evolved through relationships with others. Theoretically, the thesis draws on Mead's (1934) theory of social behaviourism, and symbolic interactionism (Blumer 1969).

An innovative and interpretative qualitative methodology, "Thematic Analysis", is developed for the analysis of interview accounts acknowledging the perspectives of participants. Analyses are presented as the subjective interpretations of the researcher but accounts are approached as partial representations of real experiences. The methodology of thematic analysis is developed through the research, drawing on grounded theory (Glaser and Strauss, 1967) and discourse analytic techniques (Potter and Wetherell, 1987).

The thesis comprises four separate studies to investigate subjective experiences of depression and the meaning of the term "depression", based on in-depth, semi-structured interviews. *Study I*, an exploratory study with a university population (not necessarily depressed), identifies themes and discourses in accounts of depression. *Study II* investigates subjective experiences of depression from patients' perspectives, based on accounts of psychiatric out-patients and patients of general practitioners who had been diagnosed as depressed, and identifies the power of the medical discourse in legitimating problems as depression. *Study III* discusses medical discourses of depression, as used by psychiatrists, general practitioners and clinical psychologists in interview accounts which emphasised the importance of organisational context. *Study IV* investigates women's experiences of motherhood and depression from participants' perspectives and based on their subjective accounts, and discusses gender identity and the social construction of motherhood as part of their experiences of depression.

The analysis indicated that for most respondents depression is both a subjective and a socially constructed experience. The powerful construction of depression as a clinical problem located in the individual may legitimate problematic experiences, but it is insufficient to explain subjective experiences of depression, which are better understood in terms of the construction of subjectivity through social interaction. The research has implications for more helpful professional and personal approaches to understanding the experience of depression.

ACKNOWLEDGEMENTS

A number of people have been critical in the progress and development of the research reported in this thesis.

My thanks are due of course to the participants in the research. I would like to thank them not only for taking part but also for their generosity in talking of their experiences, giving their time and making interviewing a rewarding experience. While the research could not have taken place without them, through their interest they also provided a continuing source of motivation and commitment.

In particular I would like to thank my supervisors, Dr. Paula Nicolson and Dr. Christopher Spencer, without whom this project would not have been possible nor come to fruition. My thanks for their belief in, their insight into and their personal and academic support for the research, and above all for their friendship.

Jill Tunaley and Dr. David Buckley have also been critical in ensuring that this project has neared completion and in keeping it going along the way. My thanks to Jill for many hours of discussion, conversation and shared office space. My thanks to David for many perceptive comments and constructive criticisms, and for much valued encouragement, humour and friendship which have added greatly to the process of research and to life overall.

There are many other people who I wish to thank including my friends and family, on whom I have inflicted many of the traumas of the Ph.D. process, for their tolerance and humour. In particular my thanks to Edward Lewis, Cathryn de Max, Jenny Ruthven, Martie Jelinek, Catherine Jockel and Elaine Boyle. Thanks too to Mr. Peter Clarke for sharing my explorations of depression, with wisdom and generosity.

Ms Judy Jackson transcribed many of the interviews with painstaking care, and enthusiasm. Ms Lynne Mallinson also provided typing and transcription, time and tea. My thanks to them, along with Mrs Marg Walker, for helping to ensure that the data reached the written page.

The Psychology Department of the University of Sheffield, under Dr. Christopher Spencer and Professor John Frisby as chairpersons, has provided me with facilities and space to pursue this research, and my thanks to everyone concerned there, from the porters inwards, for all their varied contributions.

I would also like to thank my examiners, Prof. Tony Gale and Dr. Gerry Kent, for their encouraging and constructive comments.

Last and far from least, my sincere thanks to Mr. J.H. Morton, to Dr. John Aplin and to the trustees of the Howard Morton Trust of the University of Sheffield, who not only very generously financed this research but took personal and supportive interest in its development. Their support has been critical in giving me the academic freedom and financial backing to pursue this research. I hope it has lived up to their expectations and contributes towards some of the aims of the Howard Morton Trust.

For my parents, with love and gratitude.

TABLE OF CONTENTS

CHAPTER ONE

TOWARDS A SOCIAL PSYCHOLOGICAL APPROACH TO DEPRESSION

	Page
INTRODUCTION.....	1
1 Depression conceptualised as a clinical problem.....	2
2 Explanatory models of depression.....	3
PART I: CLINICAL/MEDICAL APPROACHES TO THE IDENTIFICATION AND DEFINITION OF DEPRESSION.....	3
1. Diagnosis and symptomatology.....	3
2. The research basis of diagnostic classification systems.....	4
3. Implications for explaining depression.....	6
4 The use of diagnostic systems within the research literature.....	7
PART II : SOCIAL SCIENCE EXPLANATIONS AND MODELS OF DEPRESSION.....	9
1. The social environment.....	9
2. The meaning of individual experience.....	11
2.1 Cognitive processing.....	12
3. Meaning and relationships.....	16
4. The self.....	17
4.1 Loss, self-esteem and depression.....	18
5. Subjectivity.....	20
6. The socio-cultural environment: powerlessness, helplessness and dependency.....	21
6.1 The meaning of behaviour: socio-cultural values within relationships.....	23
7. Summary.....	24

PART III: SUBJECTIVE EXPERIENCE.....	25
1. Depression as the experience of a person.....	25
2. The value of a qualitative approach to experiences of depression and an overview of this thesis.....	25
2.1 Medical discourses of depression.....	26
2.2 Subjective experiences of depression among women.....	26
<u>CHAPTER TWO:</u>	
<u>STUDY I. TALKING TO PEOPLE ABOUT DEPRESSION: EXPLORING A QUALITATIVE APPROACH TO UNDERSTANDING DEPRESSION</u>	
INTRODUCTION.....	28
PART I DESIGN AND METHODOLOGY.....	29
Aims of the study.....	29
Sample criteria.....	30
Recruitment procedure.....	30
Sample characteristics.....	31
Interview design.....	32
The interview relationship.....	34
Transcription.....	35
Analysis of interviews.....	35
PART II RESULTS.....	39
<i>PART A: EXPLAINING TO OTHERS/ BEING MISUNDERSTOOD.....</i>	<i>40</i>
1. Definitions of depression	40
1.1 Depression a distinct state, an illness.....	40
1.2 Depression as unhappiness.....	41
1.3 Common understandings of depression.....	41
2. Describing the experience of depression/ communicating to other people.....	41
3. Denial and avoidance of depression by others.....	43
4. Recognition and validation by others.....	44
5. Rejection and fear.....	45
6. Depression is a problem for specialists.....	46

<i>PART B THE MEDICAL DISCOURSE OF DEPRESSION</i>	47
1. A liberating discourse.....	47
2. Depression as a breakdown in function: an acceptable problem.....	47
3. The stigma of mental illness.....	48
 <i>PART C DEPRESSION AS AN EXPERIENCE OF SELF</i>	50
1. Individuality, feeling different from others.....	50
2. The “real self”, distinct from everyday social experiences.....	50
3. Difference from normal everyday experiences.....	52
4. Depression is a subjective experience.....	52
5. Making sense of depression.....	53
6. Remoteness and isolation.....	54
7. Others’ views of self.....	54
8. The unacceptable self.....	55
9. Asserting self: a way out of depression.....	55
 <i>PART D AGENCY, POWER, CONTROL AND RESPONSIBILITY</i>	57
1. Depression and mind.....	57
1.1 Depression located in mind.....	57
1.2. A stress model of depression.....	58
2. The mind as agent: personal power.....	58
2.1. Reasserting control of mind and regaining personal power.....	58
2.2. Mind as agent.....	58
3. The social significance of depression: social responsibility and personal power.....	59
4. Powerlessness and adjustment.....	60
 <i>PART III DISCUSSION AND CONCLUDING POINTS</i>	62
1. Emergent themes in account of depression.....	62
1.1 Feelings of apartness.....	62
1.2 Being misunderstood.....	62
1.3 Blame, responsibility and the notion of illness.....	63
1.4 Control and powerlessness.....	63
1.5 Explanation and mystery.....	63
1.6 The experience of an unacceptable self.....	63

2. A review of methodology.....	64
2.1 Interview design.....	64
2.2. Variability of interview data.....	64
2.3 Experience and discourse.....	65
2.4 Validation.....	65
3. Summary.....	67

CHAPTER THREE:
DEVELOPING A THEORETICAL FRAMEWORK

INTRODUCTION.....	68
-------------------	----

PART I DEVELOPMENTS IN THE THEORETICAL BASIS OF SOCIAL PSYCHOLOGY.....	70
---	----

1. The crisis in social psychology.....	70
2. Recent developments within social psychology.....	71
3. Contributions to developing a new psychological perspective.....	71
4. A new theoretical perspective in social psychology?.....	72
4.1 Discourse analysis and the redundancy of the person.....	72
5. An alternative theoretical tradition within the history of social psychology....	74
6. Implications for the theorisation of depression.....	75

PART II THEORETICAL ISSUES AND RESEARCH QUESTIONS.....	76
--	----

1. Self, subjectivity and the experience of depression.....	76
2. Subjectivity.....	77
2.1 The discursive construction of subjectivity.....	78
2.2 Subjectivity: the experience of a person.....	80
3. The reflexive self.....	81
4. Meaning.....	83
4.1 Meaning as process.....	83
4.2 Meaning is personal and collective.....	83
4.3 The structure of meaning.....	84
4.4 Meaning, discourse and accounts.....	84

5. Power.....	86
5.1 Power and subjectivity.....	86
5.2 power and the experience of depression.....	87
6. Structural issues.....	92
6.1 Structuration.....	92
6.2 Social processes, organisations and institutional practices: Depression as constructed within the medical process.....	93

PART III THEORETICAL ISSUES IN

DEVELOPING AN ANALYTICAL METHOD.....95

1. Variability and commonality in the construction of depression.....	95
1.1 Variability within and between individual experiences.....	95
1.2 Common experience and abnormality.....	95
2. The interpretation of accounts of experience.....	96
2.1 The notion of the unitary individual.....	96
2.2 The social construction of depression as an individualised experience.....	96
2.3 Knowledge as an institutional production.....	97

PART IV THE RESEARCH PROCESS.....99

1. The interpretation of accounts of experience.....	99
1.1 Social and individual levels of analysis.....	99
1.2 A realist position on experience within relative accounts.....	100
2. Reflexivity within the research process.....	101
3. Summary.....	104

CHAPTER FOUR.

THEORY TO METHODOLOGY: THE DESIGN AND THE DEVELOPMENT OF METHODOLOGY

INTRODUCTION.....	105
PART I DESIGN.....	105
<i>AIMS</i>	105
1. The subjective experience of depression.....	105
2. "Depression".....	106
<i>THE RESEARCH DESIGN</i>	107
PART II THE RESEARCH PROCESS.....	110
PART III METHODOLOGY: ANALYSIS OF THE DATA.....	112
1. Discourse and the use of discourse analytic techniques.....	113
2. "Themes" and "Thematic Analysis".....	113
2.1 The notion of a theme.....	113
2.2 The development of "Thematic Analysis".....	114
A note on transcription.....	117
A note on the use of interview excerpts in the thesis.....	117

CHAPTER FIVE:
STUDY II. EXPERIENCES OF DEPRESSION: INTERVIEWS WITH
PSYCHIATRIC OUT-PATIENTS AND PATIENTS OF GENERAL
PRACTITIONERS.

INTRODUCTION.....	118
PART I DESIGN AND METHODOLOGY.....	119
1. Aims.....	119
2. Recruitment and procedure.....	119
3. Interview design.....	122
4. Analysis of interviews: The development of "Thematic Analysis".....	125
PART II RESULTS: PSYCHIATRIC OUT-PATIENTS.....	129
<i>PART A: WHAT IS THE PROBLEM?</i>	129
1. The diagnosis: identifying the problem.....	130
2. "Real" depression.....	130
3. Biological problems.....	132
3.1 Uncontrollable biochemistry.....	132
3.2 Uncontrollable hormones.....	133
4. The mystery of depression.....	133
5. Ambivalence towards or rejection of the diagnosis of depression.....	134
6. The stigma of mental illness.....	136
7. "Pull yourself together!".....	138
8. Summary.....	139
<i>PART B: EXPERIENCES OF DEPRESSION</i>	141
1. An indescribable experience.....	141
2. Being taken over.....	142
3. Not like I was? Loss of self.....	144
4. "I can't cope with life".....	146
5. Summary.....	147

*PART C: EXPLAINING DEPRESSION: EXPLANATORY
FRAMEWORKS*.....148

1. Depression is a mystery: there is no reason for it.....148
2. Explanatory frameworks: Situations.....148
 2.1 Specific causes: unemployment, loss and lifestyle.....148
 2.2 Illness as a reaction to stress.....151
3. "There's something wrong with me".....152
4. Summary.....154

PART III RESULTS: PATIENTS OF GENERAL PRACTITIONERS.....155

INTERVIEW 1: ANGIE.....155

Introduction.....155
1. Relationship.....156
 1.1 The loss of income and responsibility.....156
 1.2 Loss of autonomy and identity.....157
 1.3 Construction of Angie as the problem (by her husband).....158
2. Experience of motherhood.....160
 2.1 Feelings of inadequacy.....160
 2.2 Loss of respect, powerlessness.....160
 2.3 The social construction of motherhood and structural problems....161
3. The diagnosis.....162
 3.1 Liberating.....162
 3.2 Stigmatisation.....163
 3.3 Pathologisation.....164
4. Summary.....165

INTERVIEW 2: JOHN.....166

Introduction.....166
1. The diagnosis.....166
 1.1 Identity as depressed.....166
 1.2 The experience of depression.....167
2. The self.....168
3. Summary.....170

<i>INTERVIEW 3: PAT</i>	170
Introduction.....	170
1. What is depression? A moral discourse.....	170
2. A rational discourse.....	172
3. Loss of role and identity.....	172
4. Summary.....	173
PART IV DISCUSSION.....	174
1. Explaining depression as part of life.....	174
2. Explaining depression as an experience of self.....	175
3. Meaning and adjustment.....	175
4. Reflexivity.....	176
5. The meaning of the term "depression".....	177
6. Issues identified in Study II to be explored further in the thesis.....	178
<u>CHAPTER SIX:</u>	
<u>STUDY III HEALTH PROFESSIONALS' UNDERSTANDINGS OF</u>	
<u>DEPRESSION: DISCOURSE, DIAGNOSIS AND TREATMENT.</u>	
INTRODUCTION.....	179
PART I DESIGN AND METHODOLOGY.....	180
Aims.....	180
Recruitment and procedure.....	180
Interview design.....	181
Analysis of Interviews.....	183

PART II RESULTS.....	190
<i>PART A INTERVIEWS WITH PSYCHIATRISTS</i>	190
1. Defining depression.....	190
1.1 Organic and biological.....	190
1.2 Psychiatric illness and diagnostic systems.....	191
1.3 Distress.....	193
1.4 Experience as illness.....	193
1.5 Summary.....	194
2. The remit of psychiatry: treatment.....	194
2.1 Biological/ social.....	194
2.2 Research basis/ pragmatism.....	196
2.3 Summary.....	196
3. The medical process.....	197
3.1 Procedure.....	197
3.2 Management and control.....	198
4. Summary and conclusions.....	198
<i>PART B INTERVIEWS WITH G.P.'S</i>	200
1. Explanatory frameworks.....	200
1.1 Causation, the individual, their circumstances and the illness of depression.....	200
1.1.1 Situation and circumstances or individual biology.....	200
1.1.2 Causation.....	201
1.2 Endogenous depression: real depression is biological.....	202
1.3 Illness and the individual: Depression as an illness: containing the problem.....	203
2. The treatment of depression.....	204
2.1 Pragmatism.....	204
2.2 The treatment discourse.....	204
2.3 Depression as a medical problem.....	205
2.4 The role of the G.P. within the medical process.....	206
3. Summary.....	207

<i>PART C INTERVIEWS WITH CLINICAL PSYCHOLOGISTS</i>	209
1. Rejection of the medical model.....	210
2. Alternative models of depression.....	211
3. The roles of clinical psychologists within the health service.....	213
4. The profession and practice of clinical psychology.....	215
5. Accountability within the health service.....	219
6. Summary.....	220
6.1 Organisational theme.....	221
6.2 Constructing an alternative to the medical discourse of depression.....	222
6.3 Concluding points.....	224
 <i>PART III DISCUSSION</i>	 225
1. An illness based approach to depression.....	225
1.1 The notion of depression as an illness.....	225
1.2 The bio-medical model.....	225
1.3 A treatment discourse.....	226
2. Professional territories.....	226
3. The medical process.....	227
4. Concluding points.....	230

VOLUME 2
TABLE OF CONTENTS

CHAPTER SEVEN

WOMEN, DEPRESSION AND MOTHERHOOD

INTRODUCTION.....	231
1. Epidemiology of depression.....	231
2. Causation.....	232
PART I THE QUESTION OF GENDER.....	233
1. Depression and female reproductive biology.....	233
2. Sociological approaches to women and depression.....	234
2.1 Social roles.....	235
2.1.1 Motherhood and depression.....	235
2.1.2 Depression and the housewife role.....	236
2.1.3 Paid employment: a protective factor?.....	236
2.1.4 Social roles and individual experience.....	237
3. Subjectivity.....	238
3.1 Meaning, and subjective experiences.....	238
3.2 Subjective experience and socio-cultural contexts.....	240
4. Power.....	242
5. Summary.....	243
PART II	
THE MEANING OF MOTHERHOOD: SOCIAL CONSTRUCTION, GENDER IDENTITY AND SUBJECTIVITY.....	244
1. The choice of motherhood? The construction of social and personal identity.....	244
1.1 Social and personal identity.....	244
1.2 Social pressure and personal choices.....	245
1.3 Acceptable motherhood.....	246
1.4 The value of motherhood.....	247
1.5 The development of women as mothers: psychological evolution?.....	248

2. The social construction of motherhood.....	248
2.1 Non-problematic versions of motherhood.....	248
2.2 Scientific versions of motherhood.....	250
2.3 The incorporation of scientific knowledge into popular versions of motherhood.....	251
3. Women's experiences of motherhood.....	254
3.1 Feminism and motherhood: validating women's experiences.....	254
3.2 Motherhood as an experience of identity and self.....	255
3.3 Motherhood and transitions of identity: loss, grief and adaptation..	257
PART III ISSUES FOR RESEARCH.....	259
1. Motherhood and subjectivity.....	259
2. Summary and issues for research.....	260
<u>CHAPTER EIGHT:</u>	
<u>STUDY IV: GENDER, IDENTITY AND DEPRESSION: EXPERIENCES</u>	
<u>OF MOTHERHOOD AND DEPRESSION</u>	
INTRODUCTION.....	262
PART I DESIGN AND METHODOLOGY.....	263
Aims of the study.....	263
Design, recruitment and procedure.....	263
Sample criteria.....	263
Recruitment procedure.....	264
Participant characteristics.....	266
Interview design.....	266
Interview procedure.....	267
Transcription.....	267
Data analysis.....	267
The significance of this study within the development of methodology in the thesis.....	267
Aims in the analysis.....	268

Method of analysis.....	270
Presentation of the research account.....	272
Theoretical issues in the analysis.....	274
PART II RESULTS.....	276
Introduction to the data analysis.....	276
<i>PART A IDENTITY AND INTERPERSONAL RELATIONSHIPS.....</i>	<i>277</i>
1. Motherhood and the loss of autonomous identity.....	277
2. Validation of women as mothers.....	278
2.1 Legitimizing the role of a mother.....	278
2.2 Feeling worthless.....	279
2.3 The good wife and mother.....	280
2.4 Guilt.....	281
3. Motherhood and the experience of powerlessness.....	283
4. Loss of potential autonomy.....	284
5. Loss of self.....	285
5.1 Marriage.....	285
5.2 Motherhood.....	287
6. Summary.....	288
6.1 Acceptable women.....	288
6.2 Dominant discourses.....	289
6.3 Personal and structural issues.....	290
<i>PART B WOMEN'S EXPERIENCES OF MOTHERHOOD.....</i>	<i>292</i>
1. The social construction of motherhood: ideology, expectations and disappointment.....	292
2. Contradictory experiences in motherhood.....	292
3. An inadequate mother: blaming oneself.....	294
4. Loss in relationships: grief, adaptation and change.....	296
5. Summary.....	297

<i>PART C THE CONSTRUCTION OF "DEPRESSION"</i>	300
1. The identification of depression as the problem.....	300
2. Reflexivity and the construction of depression.....	302
2.1 Knowledge of depression.....	302
2.1.1 Conscious and unconscious knowledge.....	302
2.1.2 The meaning of "depression": avoidance of and alternatives to "depression".....	303
2.2 The reflexive reconstruction of depression in terms of subjective experiences.....	306
2.3 "There's something wrong with me": accepting the notion of depression as a medical problem.....	307
2.3.1 The uncontrollable self.....	307
2.3.2 Popular understandings of mental illness and stigmatisation.....	308
2.3.3 The pathological self.....	309
3. Explanatory frameworks: explaining depression in terms of circumstances or biology.....	310
3.1 Depression explained as a biological or hormonal problem.....	310
3.2 Rejecting hormonal explanations: explaining depression through women's lives.....	313
3.3 Coping.....	314
4. The process of help seeking: a contradictory relationship with medical authorities.....	316
5. Summary.....	317
 <i>PART III DISCUSSION AND CONCLUDING POINTS</i>	 319
 Powerful discourses and defective women.....	 319

CHAPTER NINE:
A DISCUSSION OF ISSUES EMERGING ACROSS STUDIES

PART I INTRODUCTION.....	321
PART II	
ISSUES EMERGING FROM INTERVIEW ACCOUNTS OF DEPRESSION.....	322
1. <i>SUBJECTIVE EXPERIENCES OF DEPRESSION</i>	322
1.1 Relationships to others and experiences of self.....	323
1.1.1 Feelings of apartness, being cut off from others.....	323
1.1.2 Feelings of difference and individuality.....	324
1.1.3 Feelings of powerlessness and inadequacy.....	325
1.1.4 Summary.....	326
1.2. The self.....	326
1.2.1 The uncontrollable self.....	326
1.2.2 Depression described in terms of a change in self.....	327
1.3 Difficulties in communicating feelings of depression.....	328
1.4 Summary: experiences of self in depression.....	330
2. <i>INTERPRETATIONS OF EXPERIENCES AS DEPRESSION</i>	331
2.1 Identifying depression.....	332
2.1.1 Recognition of depression : the relief of identifying the problem.....	332
2.1.2 The meaning of the diagnosis: Pathologisation and stigmatisation.....	333
2.1.3 Rejection of the medical discourse of depression as pathology.....	334
2.1.4. Contradictions in accounts: Difficulties in constructing an alternative discourse of depression to the medical discourse of depression as pathology.....	336
2.1.5 Avoiding the medical discourse: The retrospective construction of depression.....	337
2.2. Explaining "depression".....	338
2.2.1 Depression is a mysterious experience.....	338
2.2.2 Explaining depression as individual pathology.....	340
2.2.3 Rejecting medical explanations of depression as individual pathology.....	341
2.2.4 Constructing alternative (social) explanations of depression.....	342

2.3	Reconstructing "depression".....	347
2.3.1.	The construction of depression as a process of change, a complex and variable experience of self.....	347
2.4	Summary: interpreting "depression".....	350
3.	<i>THE CONSTRUCTION OF DEPRESSION AS A MEDICAL PROBLEM</i>	354
3.1.	Treatment discourses.....	354
3.2	The construction of depression as an illness.....	357
3.3	Help seeking for depression: the availability of medical help.....	359
3.4	Summary.....	361
3.5	Issues for future research.....	363
3.5.1	Defining depression: The organisation and values of health care.....	363
3.5.2	Public understanding of depression as a health issue.....	364
PART III SUMMARY.....		365
<u>CHAPTER TEN</u>		
<u>THE SOCIAL CONSTRUCTION OF DEPRESSION: DISCUSSION AND CONCLUDING POINTS</u>		
INTRODUCTION.....		367
PART I A BRIEF OVERVIEW OF THE THESIS.....		368
PART II: A BRIEF REVIEW OF THE CONTRIBUTION OF THIS THESIS TO THE SOCIAL PSYCHOLOGY OF DEPRESSION.....		370
1.	Meaning.....	370
2.	The construction of gender identity.....	370
2.1	The construction of gender identity and the construction of self....	370
2.2	The construction of gender identity: Explaining depression as loss of self.....	372
3.	The social environment.....	373

PART III METHODOLOGY.....	375
<i>PART A: THE DEVELOPMENT OF THEMATIC ANALYSIS</i>	375
1. Commonality and variability.....	375
2. Interpreting accounts as representations of experiences.....	375
2.1. The interview process.....	377
3. An interpretative approach to investigating the meanings of experiences of depression.....	377
4. The construction of self in experiences of depression.....	378
5. Discourse analytic techniques.....	378
5.1. Common social discourses.....	379
5.2. Individuals actively use and construct discourses.....	379
5.3. Discourses are constructed and acquire meaning through social interactions.....	380
5.4. Discourse, social structure and action.....	380
6. Summary of thematic analysis.....	381
<i>PART B:</i> <i>DEVELOPMENTS OF THE METHODOLOGY AND FUTURE RESEARCH</i> ...	383
1. Explaining depression as the experience of a person.....	383
2. Developing thematic analysis in longitudinal case-study designs for the investigation of depression as an on-going process.....	384
2.1 The construction of depression as a past experience.....	384
2.2. The development of medical discourses surrounding depression..	385
2.3. The evolution of shared discourses surrounding subjective experiences of depression.....	385
<i>PART C: A NOTE ON RESEARCHER REFLEXIVITY: MY PERSONAL EXPERIENCE OF THE RESEARCH PROCESS</i>	387
1. Training in social science research.....	387
2. Involvement in and commitment to the research.....	388
2.1 Responsibilities towards research participants.....	389
2.2 My personal involvement in the research issues.....	390
3. Summary.....	391

**PART IV SUMMARY: THE CONTRIBUTION OF THE THESIS
TO THE PSYCHOLOGY OF DEPRESSION392**

- 1. The use of a qualitative methodology in research on depression.....392
- 2. The meaning of depression.....392
- 3. Depression explained as an experience of self.....393
- 4. Explaining depression as a subjective experience.....394

APPENDICES.....396

REFERENCES.....417

CHAPTER ONE

TOWARDS A SOCIAL PSYCHOLOGICAL

APPROACH TO DEPRESSION

INTRODUCTION

"At the biological level, at the psychological level and at the family level, depression exerts a multitude of effects. Rarely discussed in the literature is depression at a cultural level. This is the role that socio-political structures of society play on an individual's feeling state... These cultural aspects are difficult to explore from a disease theory point of view, since many would argue that these culturally related depressed states are not 'illnesses'. But to social psychiatrists, psychologists, sociologists and anthropologists, they are important areas of study and our understanding of them is extremely important. Ring fencing depression in terms of disease - not disease is to court various confusions". (Gilbert, 1992, p.4)

Depression has been conceptualised as a disease within predominant clinical models of depression as illness, and this has limited approaches to and research on depression. Though in practice clinicians and researchers may be aware that depression cannot be adequately explained in terms of the disease model, this approach predominates within the research literature where depression is seen as a clinical problem, and defined in clinical terms through the identification of symptoms. In this thesis an alternative, social psychological approach to depression is developed. This moves beyond conceptualisations of depression as a disease.

The aim of this chapter is to identify how a social psychological approach to depression may contribute to understandings of depression and to briefly look at how depression has been understood within the clinical and social science literature. The literature on depression is wide-ranging and has drawn on many disciplines, but the emphasis has been within discipline rather than cross-discipline (Gilbert, 1992). A variety of methodologies and theoretical conceptualisations have been incorporated into research on depression. There is no single unified approach. Here the aim is to critically evaluate issues identified within these approaches and to discuss the relevance of a social psychological approach to depression, conceptualised in terms of social and interactive experience.

This chapter will identify issues which have been important to the development of the approach in this thesis, looking in particular at the identification and definition of depression as a clinical problem, and conceptualisations of depression in psychological and social science research.

1 Depression conceptualised as a clinical problem.

Depression has been understood within a scientific and clinical context within the twentieth century (Gilbert, 1992; Ussher, 1991; Jackson, 1986). But depression has been recognised since classical times (Gilbert, 1984; Jackson, 1986) and explained from within philosophical perspectives as a problem of individual understanding (Jackson, 1986) or as a physical problem, an excess of black bile leading to melancholia (Nolen-Hoeksema, 1990). It can also be understood within spiritual, religious and moral terms, which can be seen predominating within different historical periods and within the context of social and cultural history (Showalter, 1987). Understandings of depression can be seen as the product of socio-political factors (Ender, 1990), and the term depression and the labelling of experiences as depression as a cultural construction (Showalter, 1987).

The aim here, in developing a social psychological approach is to examine depression as the experience of an individual, located within a process of social interaction, and incorporated into individual subjectivity. This is distinguished from the clinical approach since depression is seen as dynamic rather than static, as interactive and on-going rather than contained within the individual, and as having meaning as a subjective experience, incorporated into sense of self and identity.

"The turn of the century saw the beginning of the application of scientific principles to the problems of mental suffering. Modern approaches reflect this advance in their attempts to quantify, verify and replicate findings. Modern approaches have focused on the notion of the psychiatric syndrome. A syndrome is a set of symptoms that go together." (Gilbert, 1992, p.16)

In the twentieth century research has been related to clinical work, the focus of which has been on depression as psychopathology (Gilbert, 1992; Nicolson, 1988). Clinical approaches have generally approached depression as a problem located within the individual. Within a clinical framework the focus has been on the identification and treatment of depression. A symptom based approach to identification is located within the medical model, combining an emphasis on quantification and replication with a focus on aetiology (Gilbert, 1992). The two questions, what is depression, and how can it be explained, represent different but linked approaches.

2 Explanatory models of depression.

Two alternative models of depression can be identified from the published research: the social science model and the clinical/ medical model (Nicolson, 1988). Both models seek to identify sources of causation. In the clinical or medical model depression is seen as an illness and individual characteristics as predisposing toward depression, (e.g. Beck, 1967, 1979; Keller, 1994; Hirschfeld, 1994), while in the social science model the causes are also seen as social and as external to the individual (e.g. Brown and Harris, 1978). The social science model emphasises the importance of the environment as a direct cause of depression. The clinical model identifies individual pathology as the source of depression, and within the clinical model individual vulnerabilities are identified and are seen as predictors of depression.

Within social science approaches the focus has been on the explanation, and prediction of depression. Environmental factors are seen as precipitating depression, given a pre-existing vulnerability within the individual.

These models are dualist, they see the individual and the environment as separate entities and do not consider the individual as located in a process of complex interaction with the environment. So causation is either individual or social. Depression is explained in terms of either individual psychology or the social environment, or in terms of individual psychological vulnerabilities and social factors.

PART I: CLINICAL/ MEDICAL APPROACHES TO THE IDENTIFICATION AND DEFINITION OF DEPRESSION

1. Diagnosis and symptomatology.

Traditional scientific and clinical approaches have defined depression with reference to symptoms, which may be objectively identified and measured. Common symptoms of depression include the psychological: loss of motivation, sadness, low self-esteem, and the physical: physical aches and pains and difficulty sleeping and eating (Nolen-Hoeksema, 1990).

For example the usual standard for classification of depression is major depression and this is the most important category in the major diagnostic systems, the ICD-10 (World Health Organisation, 1992) and the DSM-III-R (American Psychiatric Association, 1987). The DSM-III-R classification uses a list of symptoms for a diagnosis of major depression, at least 5 of which are needed during a two week period and which represent a change from previous functioning. At least one of these is depressed mood or loss of interest or pleasure, and the list includes significant weight loss or gain, insomnia,

psychomotor agitation or retardation, feelings of worthlessness, and diminished ability to concentrate. There is the proviso that symptoms cannot be explained by organic disturbance or as a normal reaction to the death of a loved one. DSM-III-R also contains superordinate and sub-classifications, for example cases are described as in partial or complete remission; as mild, moderate or severe; with melancholia; with psychotic features.

Psychiatry and clinical psychology both draw on symptom based definitions of depression. Psychiatry is limited to the medical model which looks at the problem of depression in terms of its symptoms and possible causation, whereas clinical psychology moves beyond this in order to attempt to explain depression in terms of psychological phenomena and the psychological experiences of the individual. Both see the problem of depression as contained within the individual, but whereas psychiatry is concerned with management and control of symptoms, clinical psychology might also be seen as concerned with understanding and explaining symptoms.

An important distinction is drawn between the occurrence of a symptom of depression and of a syndrome of depression. Syndromes and disorders are identified in terms of the number and severity of symptoms, the emphasis is on the severity and pattern of symptoms and a symptom alone does not define an individual as depressed. Syndromes and disorders are conceptualised as disease within the individual, and as having a common identity across individuals (Brown and Harris, 1978; Gilbert, 1992; Nolen-Hoeksema, 1990).

Since the 1970's psychiatric researchers have attempted to develop diagnostic criteria based on clearly defined symptoms (Coyne and Downey, 1991; Coyne, 1994). Psychiatric approaches since the 1970's have stressed the importance of formal diagnosis (Klerman, 1989; Robins and Helzer, 1986) partly in reaction to challenges to the professional basis of psychiatry (Coyne and Downey, 1991).

Depression as a medical phenomenon is thus defined in terms of the presence of measured and sufficiently severe symptoms, classified as syndromes. The identification of depression depends on the classification of syndromes and not merely on the presence of symptoms.

2. The research basis of diagnostic classification systems.

Syndromes of depression have been the focus of psychiatric and clinically based research. The issue of what depression is has been linked to aetiology, whether biological, psychological or social. Syndromes have been defined with reference to

aetiology not just phenomenology (Gilbert, 1992), in other words the causes of symptoms as well as the symptoms identified are used to define the psychiatric syndrome, and this may lead to confusion.

But the criteria of diagnostic systems depend heavily on the viewpoints and research criteria of the clinicians drawing them up (see Spitzer, Endicott and Robins, 1978; Gilbert, 1992). Classification systems do not represent a scientific approach to the symptoms that individuals experience as depression and are neither inclusive nor exhaustive (Lewis, 1992).

"DSM-III-R is not a scientific document that provides an extensional definition of mental disorder by listing all possible cases, in a manner comparable to a periodic table of elements. It is a social document that wears many conflicting hats and must be sensitive to a variety of clinical, forensic, professional, international, and public health issues... It emphasises for inclusion those conditions that are often seen by clinicians and researchers." (Widiger and Trull, 1991, p. 111)

DSM criteria for depression represent compromises between the viewpoints of clinicians drawing them up and are to some extent arbitrary (Nolen-Hoeksema, 1990). They represent the interpretation of symptoms as depression by clinicians and researchers based on their experience of those who enter the medical system and arrive in the clinicians' offices (Widiger and Trull, 1991), and subjective judgements on what is delivered by the working of the medical system. They are then used as criteria for research and thus the research criteria of a few clinicians can come to influence definitions of depression throughout the research literature.

Criticism of the classification systems has focused in particular on the validity of syndromes which can then come to define depression within research. Classification systems can proliferate indefinitely as new types of depression are "discovered" and this leads to questions about the meaningfulness of the original distinctions. Additional categories are added to include subtypes not presently recognised and these are often debatable e.g. late luteal dysphoric disorder (McGrath, 1990). In order to establish the discreet nature of disorders and the identification of depression as a category it is necessary to demonstrate zones of rarity between disorders (Kendell, 1975). But this has not been successful (Kendell and Brockington, 1980), and it is now accepted that insufficient evidence exists to support the hypothesis that depressive disorders are distinct from each other (Hirschfeld, 1994).

It is not clear that depression can be categorically distinguished from other psychiatrically defined and symptom based disorders. For example, there is evidence that anxiety has a high comorbidity with depression and that most depressed patients are also anxious (Watson and Clark, 1984; Kendall and Watson, 1989; Clark and Watson, 1991).

Nor is it clear that depression can be categorically distinguished from normal unhappiness. The boundary between depression as a normal mood state and depression as a state that merits clinical intervention is unclear (Kendell, 1988), and yet it is used to "do a disservice to people whose depressions do not meet diagnostic criteria by discounting their depressions as 'only normal' ", (Nolen-Hoeksema, 1990, p.5). (In Study IV (see Chapter Eight, Part II, Part C, section 4) I explore further the implications for the self-esteem of prospective patients of doctors' refusal to recognise depression as a clinical problem.)

3. Implications for explaining depression.

Classification systems can be seen as reflecting genuine confusion surrounding notions of depression, although this confusion is rarely acknowledged as classification systems are used to provide definitive definitions. This confusion is suggested by the plethora of distinctions and types of depression which classification systems have attempted to resolve, and which are to some extent historical and a sign of the constant development of psychiatric practice within the profession. Thus depression can also be classified as psychotic-neurotic, endogenous-exogenous, unipolar-bipolar, primary-secondary, in terms of predominant characteristics. The different terms and distinctions can be overwhelming (see Gold, 1992) and the classification systems at least try to draw available knowledge together in a more definitive and accessible form.

Classification depends on the use to which it is put (Kendell, 1975). It may not be exhaustively used by clinicians, and clinicians may choose to what extent diagnostic systems determine the diagnoses they make (see Chapter Six). They can be seen as professional documents to aid clinicians in their daily work by providing a common understanding of what they mean by depression and a common language within which to work, rather than as scientifically based definitions. Psychiatric classification systems arguably can be seen as providing a pragmatic means of identifying depression in brief consultations for specific professional purposes, rather than as scientifically based or definitive definitions.

However, if this is the case, psychiatric classification systems carry hidden agendas in defining what conditions should be treated as clinical problems:

"Problem definition defines boundaries and domains of expertise... all the classification debates carry hidden agendas of who can do what to whom, how preventative programmes can be organised and how resources and power is allocated. Time is money and money and resources dictate what kind of response a society will offer to those that suffer." (Gilbert, 1992, p.10)

Diagnostic systems are drawn up with reference to professional experiences and professional needs, and define boundaries and domains of expertise, and reflect issues of power within the medical profession (Turner, 1987). The diagnostic system of depression can be seen as a professional and social document rather than a scientific document (Widiger and Trull, 1991) and as used to limit the terms of expertise within the profession. Revised versions of the DSM's (American Psychiatric Association) have been interpreted as a defence of psychiatry and a reaction to the anti-psychiatry movement (see Chapter Six).

The implications of the classification systems for diagnoses are critical in terms of the recognition of patients, the disposal of patients and the maintenance of professional power and status. They define depression as a medical problem, and in particular one which comes under the expertise of psychiatrists. While others may investigate the causes of depression it is psychiatrists who, in terms of the medical system, have the power to define what depression is, who gets what treatment when, and who is allowed to treat them.

4 The use of diagnostic systems within the research literature.

The psychiatric profession is powerful within the treatment of depression, as specialists in mental health within the health care system, and the danger then is that diagnostic systems can become the basis for scientific research into the phenomena of depression where this is inappropriate. Clinical research has used research methods based on classification systems, including the use of semi-structured interviews to obtain information about a person's history, symptom status and social functioning, and depression within the research literature has been defined in terms of psychiatric diagnostic systems (Coyne, 1994).

Brown and Harris (1978) for example, defined depression for the purposes of research based on medical classification systems, even though they were aware that these are problematic and that definitions which are symptom based are themselves influenced by social factors. They suggest that they follow clinical measures simply because they are unwilling to challenge or question the supremacy of clinical judgements. At the same time as they recognise that psychiatric standards are the product of social factors, they do not

pursue the implications of this to challenge the validity of such measures as definitions of depression. On the contrary they wish to avoid any such questioning and use clinical judgements in order to validate their own work:

"We have explained our decision to throw in our lot with the best in the clinical tradition and we accepted that at present at least there was no other way of validating a measure of clinical depression than by using clinical judgements of what should be counted as a case. We have noted already that psychiatric standards regarding diagnosis are bound to be influenced by a range of wider social factors. In this potential flux our aim was to deal with phenomena about which there would be general agreement among psychiatrists and on the basis of this delimit clusters of symptoms about which most would have little hesitation in calling clinical depression". (Brown and Harris, 1978, p.31).

This places them in a dilemma since they wish to avoid the question of whether depression as psychiatrically defined is abnormal, at the same time as they argue that depression can be understood as a normal reaction to abnormal experience. The question of whether depression is disease or illness is left unresolved. They use psychiatric diagnosis as a basis for the identification of depression in research precisely in order to avoid the question of what depression is:

"But there were no clear guidelines which laid down precisely that a woman was or was not clinically depressed... Was it a sign of clinical disturbance to wait for social contact to rescue her from her misery and anxiety rather than to go out and seek it herself? On the other hand was it not normal to feel lonely and sad if one saw but few people and had no compelling desire to get out of bed in the morning? And, if it was normal, was it a clinical disturbance?" (Brown and Harris, 1978, p.31)

PART II : SOCIAL SCIENCE EXPLANATIONS AND MODELS OF DEPRESSION

1. The social environment

From a social science perspective, Brown and Harris (1978) specifically repudiate Aaron Beck's (1971) claim that depression can be explained as a clinical phenomenon in terms of individual pathology, as faulty information processing. Depression is explicable in terms of the external social environment rather than in terms of individual pathology:

"[Aaron Beck suggests that] there is in other words something wrong with the person in the first place. We believe that this is an unnecessary stipulation. Depression may also come from entirely accurate conceptualisation, the "fault" lying in the environment rather than in the person... This view suggests that responses to the environment need to be studied as part of a broad investigation of depression in a clinical population; it calls for research in which the guiding principle is first to explain as much as possible in terms of everyday experience in that community." (Brown and Harris, 1978, p.83).

Since there is no explicit consideration of the external environment Beck's (1971) claim that depressives have pathological patterns of thinking is merely an assumption (Coyne, 1989). It has been questioned in an extensive debate on depressive realism. There is little evidence to suggest that individuals' cognitions are in fact distorted in depression and evidence has suggested that the cognitions of people who are depressed are less distorted than both "normals" and non-depressed psychiatric patients (see Layne, 1983). The concept of depressive realism supports claims that depression is linked to accurate perception of the environment and that people are depressed because their lives are depressing (Coyne, 1989). Evidence of depressive realism thus fundamentally undermines the core assumption that depression is pathological and that it can be explained in terms of individual pathology and conceptualised as faulty cognitive processes; it may be the accuracy of cognitive processes which is problematic.

Brown and Harris (1978) on the other hand characterise depression as a normal reaction to abnormal and external stresses, as a social phenomenon which can be explained through the social environment. But this does not explain its occurrence in individuals:

"In explaining such findings we have viewed clinical depression largely as a social phenomenon and have developed a model which in terms of the presence and absence of three factors explains a good deal about the aetiology of *all* forms of depression. The *provoking agents* influence when the depression occurs, the

vulnerability factors whether these agents will have an effect, and the *symptom-formation* factors the severity and form of the depressive disorder itself. The model tells us that in some way the factors are linked to the disorder. It does not tell us how or why". (Brown and Harris, 1978, p.270. Their italics.)

Factors in the immediate social environment are identified in terms of their link with clinical depression, but not in terms of the meaning of environmental experience to the individual who suffers from depression. The emphasis is on the social environment of the individual and the links between this environment and clinical depression as a social phenomenon.

In mainstream social science approaches the social environment has been conceptualised in terms of social variables external to the individual. For example, the concept of social support has been used to explore the relationship between a person's social relationships, life events and their experience of depression. Brown and Harris (1978) identified lack of a confiding relationship as a vulnerability factor for depression. The connection between social support and distress rests on the assumption that it is the supportiveness of relationships which is consequential (Coyne and Bolger, 1990). In much of the research literature social support has been understood as a static, identifiable and measurable variable, through which the individual's social transactions with their environment can be explained (Coyne and Bolger, 1990).

An extensive literature has demonstrated the relationship between social support and well-being (Cohen and Willis, 1985; Sarason and Sarason, 1985; Coyne and Bolger, 1990) and between life events and psychological distress (Thoits, 1982). Social support has been assessed in terms of cognitive appraisal, the individual's perception of the support which they experience (Barrera, 1981; Coyne and DeLongis, 1986). It has been proposed that social support can be assessed as an entity which is independent of its contextual framework, and independent of contextual variables which influence its quality and effectiveness (Shumaker and Brownell, 1984). But there is confusion as to the relationship between social support and clinical depression, which has been conceptualised within in opposing frameworks, for example social support has been conceptualised as a direct provoking agent (lack of support constitutes strain) and as a vulnerability factor (social support moderating the effect of life stress), (Vilhjalmsson, 1993).

Alternatively social support can be seen as a reflection of a set of circumstances and the particular transaction between a person and their environment (Coyne and DeLongis, 1986). The individual can be conceptualised as active within a process of interaction

rather than as the passive recipient of social support. The social environment is complex. It seems to me that the identification of social support as a variable oversimplifies the process of interaction and neglects the question of how individuals come to experience support within particular relationships, the meaning of support to the individual, and the implications of the relationship for their sense of self. The individual experiences the social environment in an interactional process which involves looking at questions of subjective meanings.

2. The meaning of individual experience.

Beck (1971) argued that it was how the world was understood which was critical as a source of psychopathology and that what happened in the external world was not of importance (Beck et al., 1979). This rests on the assumption that depression is a form of psychopathology, and as psychopathology is the result of faulty conceptualisation leading to excessive or inappropriate affective disturbance.

"As is apparent, depressed persons are apt to structure their thinking in relatively primitive ways. They tend to make global judgements about events that impinge on their lives. The meanings that flood their consciousness are likely to be negative and extreme. In contrast to this primitive type of thinking, more mature thinking automatically integrates life situations into many dimensions or qualities (instead of a single category), in quantitative rather than qualitative terms and according to relative rather than absolutistic standards. In primitive thinking, the complexity, variability and diversity of human experiences and behaviour are reduced to a few crude categories." (Beck et al., 1979, pp.14-15)

Brown and Harris (1978), in an approach to depression which attempts to avoid pathologising depression, emphasised the centrality of understanding the individual's experience of their world to understanding the causation of depression. They suggest that attention should be paid to the ways in which a person understands their experiences, and that they have provided a foundation for this:

"Our approach in no way detracts from the importance of a person's experience of his or her world - indeed it is just this that is central to our theoretical ideas about the aetiology of depression. Further we are fully aware that we have not exhausted ways of looking at what we have studied. In future work, for example, we need to look in far more detail at the way women think about and experience their depression. It is important to know, for instance, how many women describe characteristic symptoms such as slowness and lethargy in apparently

moral terms such as laziness. In our work we have attempted to provide the foundation for such studies.” (Brown and Harris, 1978, p.274)

Beck (1971, 1979) also emphasised the importance of how a person understands their experiences, believed that depressed persons understood their world negatively and that this understanding could be measured . However unlike Beck, Brown and Harris (1978) argue that meaning is determined through social structure and experience and that subjective accounts of the meaning of events can be ignored, though recognising the importance of individual constructions of meaning.

However Brown and Harris (1978) do not appear to be aware of the contradiction between their aim of looking at individual meaning and the deliberate omission of any consideration of the subjective meaning of an event for the woman concerned. The implication from their approach is that since depression is a common experience it can be explained in common terms, through social factors. Brown and Harris approach meaning as a social construct. Brown and Harris (1978) devised contextual ratings of the threat posed by events: events were assessed by an independent panel, on the basis of the circumstances in which the woman experienced an event, in terms of the threat posed by an event for the average woman in similar circumstances. Subjective accounts were to be deliberately ignored and their effect minimised. This contradicts the aim, above, of looking at "person's experience of his or her world".

"We have already discussed the problem we felt in developing such scales: since in the course of discussing each event we inevitably learnt a great deal about how each woman felt and reacted we risked introducing possible bias in our ratings. To deal with this we developed contextual measures of threat which deliberately excluded any consideration of what a woman told us about the way she had personally reacted to the event. We wished these contextual measures to retain an important, perhaps crucial, element of meaning while ignoring what we had obtained by way of self-reports of threat and unpleasantness. " (Brown and Harris, 1978, p.91)

2.1 Cognitive processing

As mentioned above, Beck (1971) argued that depression can be understood in terms of depressed persons' misperceptions of the environment, and the problem of depression characterised as lying in their primitive thought processes.

Clinical depression has been identified as characterised by misperceptions of the environment. These take the form of the cognitive triad, a prolonged and pronounced

negative bias, seen in selective abstraction (the tendency to focus on negative events), overgeneralisation (the tendency to generalise from specific negative events to negative expectations of the world in general), and negative self- attributions (seeing oneself as causing negative events) (Beck, 1967, 1983).

Beck et al. (1979) explain the maintenance of the cognitive triad in the face of supposedly contradictory evidence through the concept of schemas, stable styles of cognition. These underlie the continued misinterpretation of the environment by the depressed person. These schemas may be activated by a particular situation and are also maintained by distorted perceptions of the environment.

Although the focus is on the individual the person is implicitly ignored and reduced to cognitive processes. Within cognitive models depression is seen as divorced from the nature of the person's involvement in everyday life, and issues of their relationships with others and how they respond to others are ignored (Coyne, 1989). The assumption of the primacy of cognitive processes is unchallenged within the cognitive perspective, and there is little regard for the lived experience of persons:

"The challenge [in explaining depression] is not one of simply linking the processes assumed by cognitive models to the environment. Rather, it is a matter of ceasing to look exclusively to idiosyncratic cognitive processes for explanations of what can better be understood in terms of the observable exchanges of depressed persons with their environment. It is a matter of rekindling curiosity about what the lives of depressed persons are like and ceasing to ignore obvious problems that are not just in their thinking. It is a matter of no longer trivialising the distress of depressed person and of no longer doing them the injustice of assuming that it is their thinking that is responsible for their predicament". (Coyne, 1989, p.239)

The cognitive constructs used by Beck indicate but do not develop the importance of individual experience within relationships. The cognitive triad, a negative view of the world, the self and the future has been characterised as typical of depressive thinking, and consists of the person's negative view of himself, that he or she is worthless. The person also has a negative view of the world given their current experiences, as making exorbitant demands on them. They have a negative view of the future as one of continuing difficulties and hardships (Bebbington, 1985).

Although there is no consideration of the individual's experiences in relationships with others, the cognitive triad is a relational concept (Haaga, 1991) since it is concerned with

a person's view of the world as making exorbitant demands on them and preventing them from carrying out their life goals, for example the view of the future describes the interaction of the self and the world extended into the future (Bebbington, 1985). The cognitive triad focuses on the person's experience of self, and could be reduced to a single dimension, that of the negative view of self (Haaga, 1991), but Beck does not directly address the questions of what the self is and how the self is experienced.

The model ignores the complexity of individual experience. It is general and non-specific and characterises thinking in depression through broad generalisations. It suggests that depression is the result of irrational thinking. But there is little evidence that depressed thinking is distinguished because illogical and weak (Haaga, 1991).

Attribution theory attempts to explain how individuals' social and environmental experience can lead to depression through looking at how individuals make sense of their environment. The attribution model (Abramson, Seligman and Teasdale, 1978) was a reformulation of learned helplessness theory (Seligman, 1975). One aspect of learned helplessness theory was that it had equated helplessness in animal behaviour, as animals were unable to control negative outcomes of events, with depression in humans (Seligman, 1975), but this ignores human capacity to reflect upon events. The reformulated theory (Abramson, Seligman and Teasdale, 1978) attempted to identify more specific experiences of helplessness, and how these are related to individuals' understandings of events by specifying causal attributions. Depressed individuals are characterised as making stable, global and internal attributions for events. They see themselves as responsible for failure which is not limited to a specific case and which will be generalised to the future.

The attribution model has been further developed. It has specifically been used to look at how and why negative life events contribute to the onset of depression in developing a hopelessness based sub-type of depression (Abramson, Metalsky and Alloy, 1989), which merely defines a specific sub-type of depression in terms of an hypothesised cause. It has also been specifically been used to look at why some individuals are vulnerable but not others. For example, it has been developed to look at attributions of blame for marital violence (Andrews and Brewin, 1990) and the relationship between self-blame and depression given the high incidence of depression among women (Andrews and Brown, 1988), connecting attributions to early life experiences.

The model suggests that depression is the logical result of thought processes, and assumes a direct relationship between thoughts and the emotions experienced in depression. But work in attribution has mostly been laboratory based and the empirical

evidence is weak (Coyne and Gotlib, 1983; Barnett and Gotlib, 1988; Abramson, Metalsky and Alloy, 1989). Although helplessness is itself explained in terms of causal attributions the question of how depression develops from helplessness is unanswered (Abramson, Metalsky and Alloy, 1989).

Within the attribution model depression is explained in terms of the individual, in terms of their attributions, and it is assumed that these are stable and contained within the individual. The concept of attributions is itself problematic. In his review of the extensive literature on attributions and their relation to depression, Coyne (1989) argues that there is no evidence that people actually do make attributions, nor that attributions guide individuals' behaviour and affect:

"There is a basic circularity of reasoning from which this large literature has yet to escape: Depressed persons make depressive attributions because of the operation of a depressogenic attributional style, and we know this because they make depressive attributions.

One can even ask a more basic question of what does it mean to make an attribution. Surely from time to time we all stop and ponder a provocative event and deliberate on how it might have come about. Yet what evidence is there that we do this routinely, or that it guides our behaviour and determines our affect?" (Coyne, 1989, p.233).

No account is taken of the role of the social environment in the formation of attributions. The implication of the attribution model is that the individual is self-contained in forming attributions, but also that notions of individual responsibility, or internal attributions, are formed in comparison with others, since the model implies that events would not have been uncontrollable for others. Thus a process of social comparison is implied which the model takes no account of (Bebbington, 1985). The emphasis is on individual attributions rather than on the content of events, social context, or what events actually occur.

Brown and Harris (1978) claim to explain depression through social causes but two models of causation are used: a social model and a cognitive model (Bebbington, 1985). Depression is not fully explained in terms of social causation. The variation in occurrence of depression in individuals is explained through the concept of the cognitive set, the mechanism through which social factors lead to depression in individuals. Individuals with lower self-esteem are more likely to react to loss with depression. It is only through cognitive set that the occurrence of depression in some individuals rather than others can be explained through and linked to social and external factors.

"As academic sociologists for understandable reasons we gave priority to external factors such as social relationships and employment. But nonetheless cognitive set plays a critical part in our theory, and in psychological theory this would rank as an enduring personality feature... It should be clear that we see cognitive set as merging into emotional responses to events and these reactions blending with symptoms. " (Brown and Harris, 1978, p.264)

Yet it is not clear what self-esteem is, and the notion of cognitive set is used as the mechanism through which the environment results in the individualised experience of depression, instead of exploring the subjective meanings of events for individuals.

3. Meaning and relationships

An interactional model suggests that depression may be a dynamic and social experience (Coyne, Aldwin and Lazarus, 1981) rather than located in the individual. It suggests that understanding of depression must take account of the social system as a complex process in which the individual is actively involved.

From this perspective depression can be seen as part of a dynamic process, an on-going interaction between the individual and their environment. Problems of depression can be seen as maintained through transactions of the individual with their environment (Coyne, Aldwin and Lazarus, 1981).

Communication is complex and the individual's social experience is shaped through communication at many levels (Coyne, 1976). What is critical is individual meaning as formed through interaction within relationships, and how meaning is formed through incorporating social experience. Relationships may be conceptualised in terms of shared routines and meanings (Coyne and Bolger, 1990), through which the impact of life events are mediated, and through which individuals interpret their social environment.

Depression has been conceptualised as a loss of self mediated through role relationships (Oatley and Bolton, 1985). The loss of an important role, for example through unemployment, which has been of primary importance in defining a person's sense of self, amounts to a loss of self, and the experience of depression. Oatley and Bolton (1985) developed Brown and Harris' (1978) model of the social causes of depression in a social cognitive model in which depression is conceptualised as loss of self. The self was conceptualised as formed through social interaction based on G.H. Mead's (1934) theory of social behaviourism (see Chapter Three). It is conceptualised as maintained through the expected behaviour of another in a role relationship.

Within Oatley and Bolton's (1985) model, provoking agents, life events which are identified as precipitating depression (Brown and Harris, 1978), are conceptualised as events which present a threat to a vulnerable sense of self, and vulnerability as the extent to which selfhood is invested in particular role and relationships based around that role. The source of depression is the discrepancy between the actual behaviour of the role-other (the other person in a relationship constructed around a role) and the expectations derived from the individual's cognitive model of the role other, since the fulfilment of expected patterns of behaviour is needed in order to confirm the individual's sense of self.

“We propose that provoking agents increase the risk of depression where the sense of self is realised in a role or roles. A role provides an identity and is bound up with personal goals, plans and expectations.” (Oatley and Bolton, 1985, p.376)

4. The self

The self can be understood in terms of interactive social processes, through which the individual experiences their self through the ways in which they are seen by others and learns to react to the actions of others:

"It is the social process of influencing others in a social act and then taking the attitude of others aroused by the stimulus, and then reacting in turn to this response, which constitutes a self". (Mead 1934, p.171).

The self has been conceptualised as constructed through the internalisation of social experience in mental representations. For example, Bowlby (1980) argued that the child's model of self and others is an internalised mental representation based on early experience in attachment relationships. Object relations theorists developed the model of self as an internal representation, emphasising the role of interactive social experience in a relational model (Greenberg and Mitchell, 1983). In this model internal representations of self and others are based on the child's interpersonal experiences, relationships are built up between these representations, and shape the child's expectations of interpersonal experiences and their behaviour. However these approaches have not explained how an individual incorporates social experiences into their sense of self.

Oatley and Bolton (1985) argue that the self can be understood as a cognitive construct and the self is conceptualised as the compilation of rules governing role behaviour.

Depression is conceptualised as a loss of self, where a critical role is lost and the model of self no longer confirmed by expected behaviour of others, in relationships based on the lost role :

“The models of self and other in a particular role compose the rules that have been compiled over a series of interactions to carry out mutual or supposedly mutual plans.” (Oatley and Bolton, 1985, p.379)

The social role is taken as the unit of analysis. The self is seen as created through a role or roles. The experience of role is seen as internalised by the individual. The focus of the model is on social experience, and the question of how the individual makes sense of and incorporates experience into self is left unresolved (Nicolson, 1988). The location of the problem is in the social environment in terms of the experience of a role.

Oatley and Bolton (1985) suggest that an individual may have common experiences across roles. However, a role may involve several relationships within which the individual experiences their self in diverse ways. Relationships rather than roles may be a more appropriate approach to looking at the meaning of experience. A single role may have diverse and contradictory meanings, rather than being unitary. The problem may be how the individual reflects on their diverse experiences within or across roles, and how these experiences are constructed by the individual and incorporated into sense of self.

Within the Oatley and Bolton (1985) model, the self is conceptualised in terms of an internal cognitive construct, although they claim to base their work on Mead's (1934) social behaviourism. There is no account of the individual as actively reflecting upon their social experience, in the construction of meaning and subjectivity. The self is seen in terms of a static model derived from the rules governing role behaviour and which is contained within the individual role.

4.1 Loss, self-esteem and depression

The concept of self-esteem is used to explain depression as a reaction to loss. Self-esteem is conceptualised as lowered through the experience of loss, but is internal to the individual.

Brown and Harris (1978) characterised depression as a normal reaction to abnormal environmental stresses and in particular as a reaction to loss events. Drawing on the work of Freud and Bowlby they conceptualised the effects of losses in terms of loss of self:

"Basically we have seen loss events as the deprivation of sources of value or reward. We now go further to suggest that what is important about such loss for the genesis of depression is that it leads to an inability to hold good thoughts about ourselves, our lives and those close to us." (Brown and Harris, 1978, p.233)

Self-esteem has been used as a critical mechanism in explaining how experiences of loss lead to depression. Freud (1917) explained depression as a reaction to loss which is explained through internal drives, as impoverishment of the ego, as loss is relegated to the unconscious and self-esteem is lowered. Bowlby (1980) also linked loss to an impoverished view of self. He developed a model of depression as reaction to loss, involving distorted processes of mourning and pathological changes in self-evaluation, for which the individual is prepared by inadequate attachment bonds in childhood. Kohut in his work on Self Psychology argues that individuals experience a loss of self-esteem as they experience self-fragmentation (Gilbert, 1992). He argues that the self is constructed and experienced through interactive social experience, and through relationships with others. The self is seen as interactive and reflective, and depression is conceptualised as the experience of a fragmented or incohesive sense of self (Gilbert, 1992).

These models operate at a general conceptual level. The concept of self-esteem is linked to the experience of loss in the social environment and to the construction of self. They leave it unclear how self-esteem is formed within particular social experiences, and how social experiences are incorporated into the self. Brown and Harris (1978) criticise psychoanalytic approaches for focusing on internal psychology and neglecting environmental experience, but are themselves unable to explain how self-esteem is formed through social experience and simply use it as a mechanism for depression in their own model. Although they conceptualised self-esteem in terms of a woman's expectations of self, and related it to the social construction of role identities and the conceptualisation of oneself as successfully fulfilling a role, they did not develop a model of the self formed through social experience, in which the issue of self esteem could be explored. It is unclear what role identities are, and the relationships between the concepts of roles, identity, and the self are inadequately theorised.

"Consideration of the issue in terms of role identities relates it to the social structure which is where we think it belongs. For it is in the perception of oneself as successfully performing a role that inner and outer worlds meet, and internal and external resources come together." (Brown and Harris, 1978, p.247)

Brown and Harris (1978) here imply but do not explicitly develop the idea that, when one perceives oneself as unsuccessful in performing a role, there is divergence between inner and outer resources, that the person's internal and external worlds do not come together, that in some ways in depression one is not integrated into the external or social world.

Although self-esteem has been used as a critical mechanism in explaining how experiences of loss lead to depression it is unclear what self-esteem is, what the meanings of particular losses are for individuals and how these lead to a changed experience of self. The question of how losses are incorporated into the experience of self is not explored, since self-esteem is used as a mechanism to explain how loss leads to depression without investigating its meaning in relation to subjective experience.

5. Subjectivity

The issue of how the self is experienced in depression remains problematic. Depression is assessed in objective terms, according to symptom based measures, and is explained through internal cognitive mechanisms or external social factors. This leaves unresolved the problem of how the individual experiences depression. The meaning of individual experiences is recognised as critical (Beck et al., 1979; Brown and Harris, 1978) but is not explored at the subjective level, as the experience of a person, since the individual person is not the focus of research.

Depression has not been approached as a subjective experience since the emphasis has been on depression as an objective phenomenon, rather than on the variability of individual experience. Within this framework the person is seen as the location of the problem of depression and the focus is on depression rather than the person.

Depression is conceptualised as a static experience, which can be measured and assessed objectively. It is seen as contained within the individual. The aim is to explain it. The models reviewed above have identified social factors in the explanation of depression, but depression itself has remained located in the individual and conceptualised in terms of a cognitive or internal problem.

This is explicable in terms of dualist models prevalent throughout psychology (see Chapter Three for further discussion). The power of the dualist model means that depression is seen as located in the individual, since it is the individual who experiences depression. Social or environmental causes are conceptualised as external to the individual.

The self is linked to social factors in the environment through the concept of self-esteem, which is used to explain depression as a reaction to loss. Self-esteem is essentially a cognitive or internal mechanism through which environmental or social events are seen as leading to a changed experience of self. Models of depression in the psycho-analytic literature suggest, but do not develop, models of self formed through social interaction. Oatley and Bolton (1985) proposed a social cognitive model of the self developed through role relationships in terms of the internalisation of rules governing role behaviour. The experience of self is essentially social, interactive and cognitive. However, while Oatley and Bolton (1985) base their work on an interactive model of self, and the occurrence of depression is explained as the behaviour of others fails to maintain the cognitive model of self, depression itself is conceptualised as a problem or deficit located within the individual and is not itself conceptualised as an interactive or social experience.

6. The socio-cultural environment: powerlessness, helplessness and dependency

Gilbert (1992) has argued, from an evolutionary perspective, that depression can be understood as the experience of marginalisation and as an experience of powerlessness. He recognises the importance of a socio-cultural analysis to understanding depression and argues that this has been neglected within psychological perspectives.

As introduced earlier, learned helplessness theory (Seligman, 1975) suggested that individuals experience depression when they attempt to and fail to control events, and that the central issue is controllability:

"When a traumatic event occurs it causes a heightened state of emotionality that can be loosely called fear. This state continues until one of two things happens; if the subject learns that he can control the trauma fear is reduced and may disappear altogether; or if the subject finally learns he cannot control the trauma, fear will decrease and be replaced by depression." (Seligman, 1975, pp. 53-54)

Seligman suggests parallels between the state of helplessness and that of depression but he does not suggest how helplessness leads to depression (Abramson et al., 1978). The reformulated version of the model (Abramson et al., 1978) attempted to look at how individuals made sense of events and proposed that stable, global and internal attributions for negative life events are linked to the experience of depression. In other words, that it was when individuals saw themselves as unable to control their environment that they became depressed, when this was associated with the occurrence of negative events.

The human environment is a social environment and this was neglected by Seligman (1975) in his analogy to animal behaviour, and in Abramson et al.'s neglect of attribution as a social comparative process (Bebbington, 1985). The issue of control implies lack of power, which is a social phenomenon, and implies taking account of the socio-cultural environment.

I would argue that power is relative, is experienced in relationships with others and is constructed through those relationships. The experience of depression may be conceptualised as one of powerlessness within relationships. Within immediate relationships the values of the wider socio-cultural environment may be incorporated into the individual's experience and its meaning. The experience of depression can be reconceptualised in terms of powerlessness within a relationship.

Jack (1991), investigating women's experiences of depression in intimate relationships, argued that women experience themselves as powerless and subordinate within their relationships with men and that this amounts to a denial of self. This suggests that women's experiences can be understood as powerlessness in their relationships, and what is at issue is how they experience themselves within relationships.

Co-operative behaviour and a sense of relatedness have been identified as features of female behaviour and psychology which are devalued in male centred approaches where autonomy is valued (Gilligan, 1982). Gilbert's (1992) approach to the evolutionary significance of behaviour may be based on a male centred model, where the importance and implications of female patterns of co-operative behaviour in generating a sense of involvement and belonging is ignored. From this perspective the issue is not simply one of individual powerlessness, but a socio-cultural question of what particular forms of behaviour are valued.

Jack's (1991) work on women's experiences of depression is a socio-political analysis which is concerned with the construction of meaning. She recognises a background of collective ideas about femininity, although she does not claim to be able to generalise from the observations of the women she interviewed, and she takes account of socio-cultural context in interpreting the accounts of the women she interviewed:

"In order to hear the message of these depressed women, we need to take into account their social context, which includes the lived reality of women's subordinate status as well as a cultural history that has demeaned women's orientations." (Jack, 1991, p.25)

The wider social and cultural environment and the importance of behaviours cannot be assessed independently of the meanings and values attached to those behaviours. An interactional perspective implies looking at the incorporation of social experience by the individual and at the meaning of social experience to the individual. This involves taking account of the socio-cultural environment as shaping the behaviour of individuals and the meaning of that behaviour.

6.1 The meaning of behaviour: socio-cultural values within relationships.

Brown and Harris (1978) argued that depression should be explained in terms of a person's everyday experience in the community. Behavioural approaches, as in the learned helplessness model (Seligman, 1975), interpret behaviour on a micro-level, where behaviour is used to hypothesise the internal processes of the individual. But it has been argued here that behaviour is meaningful in terms of relationships with others and that behaviour and its meaning within relationships incorporates wider socio-cultural values, and this should be taken into account.

From a behavioural perspective the notion of reinforcement has been used to link depression to a deficit in interpersonal experience. For example, Costello (1972) argued that depression occurs when positive reinforcers cease to be effective. Lewinsohn (1974) suggested that depression was related to a low rate of response contingent positive reinforcement, which could arise from few reinforcing events in the environment or a lack of social skills, and that the interpersonal behaviour of depressed individuals is an important modulator of the type and frequency of the reinforcement they receive from others. However, this approach ignores any question of the meaning of social behaviour to the individual, or the significance of behaviour as an interaction understood within the wider socio-cultural framework.

Behavioural problems have also been conceptualised in terms of personality deficits of dependency, or need for reinforcement, taking no account of the fact that reinforcement is a normal human need nor of the significance of reinforcement behaviours given the specific social structure of individuals' roles and relationships with others. It has been suggested that depressed persons may be particularly "dependent" on others for reinforcement and that the fault lies in their personality, as in Arieti and Bemporad's (1980) work on the dependent personality; Beck's (1983) concept of the sociotropic or socially dependant personality; and Birtchnell's (1988) work on the relationship between dependency and the higher prevalence of depression in women. However, these approaches identify dependency while ignoring the actual social experience of individuals, and dependency is objectively defined regardless of the meaning and function of individual behaviours.

The location of the problem is seen as lying within the individual, in terms of their dependency as a deficit of personality. However, traditional female roles and concepts of femininity overlap with the concept of dependency and dependency cannot simply be understood as a static characteristic. An interactional perspective could suggest that dependency can be better understood as a function of role (Cadbury, 1991) rather than as an innate psychological characteristic which is associated with depression (Birtchnell, 1988). An interactional perspective explores the impact of the environment in determining behaviour, and examines the meaning and function of that behaviour as on-going process of adult development (Cadbury, 1991). An analysis of social power relations is needed, to help to make clear what exactly is meant by the concept of dependency and to facilitate an awareness of different types of dependency (Cadbury, 1991), rather than an oversimplification of the notion in terms of psychological characteristics.

7. Summary

Depression is a subjective experience, which incorporates values and meanings constructed at interpersonal and socio-cultural levels. Others in relationships may embody the values of the wider socio-cultural environment.

A symbolic interactionist approach may be used to look at the meaning of subjective experiences of depression as constructed through relationships and incorporating socio-cultural values. While Oatley and Bolton (1985) claim to base their social cognitive model of depression on Mead's (1934) work they fail to look at the subjective meaning of experiences of depression, and instead propose a model which looks at the causes of depression. These are seen as lying in the social environment and as directly internalised by the individual. There is no attempt to look at how social experiences are incorporated into one's sense of self, nor at how individuals interpret experiences through reflection upon them. Alternative epistemologies and their application to understanding depression will be discussed in Chapter Three, based on a symbolic interactionist approach to depression as the dynamic experience of a person developed through processes of social interaction.

PART III: SUBJECTIVE EXPERIENCE

1. Depression as the experience of a person.

The meaning of behaviour can be approached at the level of the person. Depression is the experience of a person involved in social processes. While this is implied in perspectives discussed above, there is a failure to look at depression from the point of view of the person experiencing it. The aim of the projects discussed in this thesis is to look at subjective understandings and experiences of depression.

The question of how the individual themselves interprets their everyday experience and how this is incorporated into their experiences of depression is based on an understanding of meaning as subjective. How do individuals experience themselves in society? How do they understand the experience of depression? Do they experience themselves as powerless, and how is this incorporated into their understanding of experiences of depression?

These questions can be approached through looking at how individuals themselves account for their experiences, at how they interpret those experiences, and at how they attempt to make sense of them. While the mainstream approaches discussed above have attempted to explain depression they have not directly addressed how individuals themselves experience depression or account for their own experiences. The person experiencing depression may be the best source of information about what they are experiencing, how they experience depression as part of their life, how depression is experienced as part of their everyday social experience, and how they feel about and perceive themselves.

2. The value of a qualitative approach to experiences of depression and an overview of this thesis

Interpretations of subjective experience as "depression" will draw on understandings of what the term "depression" means. An analysis of subjective accounts of depression involves taking account of the meaning of 'depression' as socially constructed and incorporated into individuals' accounts. It means looking at what individuals experience as well as how they interpret this experience. A qualitative methodology can be used to look at individuals' accounts in a deconstructive analysis grounded in accounts of subjective experience (see Chapters Three and Four).

Study I looks at how a qualitative approach might contribute to understandings of depression and identifies emergent themes for an analysis of how the experience of depression is commonly understood within accounts given. Further studies were then

constructed to examine understandings of depression among patients receiving treatment for depression (Study II, Chapter Five) and among health professionals (Study III, Chapter Six), and among women who were mothers (Study IV, Chapter Eight) where it was also asked whether and in what connection individuals identified themselves as depressed.

2.1 Medical discourses of depression

“Depression” is powerful in that depression is used as a common and everyday term as well as a specific medical and clinical term. The clinical perspective implies that depression can be approached as an illness and psychopathology, as located in the individual and an objective entity. There are problems in defining depression in a symptom based model, but medical definitions of depression are powerful. But do individuals themselves see depression as a medical problem, as an illness or psychopathology? How is a medical type discourse of depression as illness incorporated into their interpretations of their experiences?

The power of medical discourses surrounding conceptualisations of depression as an illness is addressed in studies of patients’ accounts of depression (patients of general practitioners and psychiatric out-patients, see Study II, Chapter Five) and studies of health professionals’ accounts of depression (Study III, Chapter Six). Is a medical interpretation of depression internalised by patients, through the process of treatment for depression within the medical system? What is its relationship with alternative understandings of depression, if any? How powerful are diagnostic approaches in shaping understandings of depression among health professionals?

2.2 Subjective experiences of depression among women

Brown and Harris (1978) did not take into account the individual women's subjective accounts of the meaning of their experiences, and instead used contextual ratings made by an independent panel of assessors. However, they argued that social factors led to depression through the mechanism of self-esteem and that women experienced depression as part of their everyday lives, as they failed to live up to their expectations of themselves as wives and mothers. How important to women themselves are their experience in roles as wives and mothers? How do they experience and perceive themselves in these roles? Do they account for experiences of depression in terms of these experiences? How important is gender in the experience of depression, and in the construction of self and identity?

Oatley and Bolton (1985) suggest that depression can be conceptualised as loss of self, when important role relationships are lost. But how is gender incorporated into role?

What is the meaning of a role? How are experiences in roles incorporated into identity and sense of self? How is gender identity constructed in role relationships? How far can the subjective experience of depression be theorised in terms of the incorporation of social experience into self?

These questions are addressed in the project on women's experiences of depression as mothers (Study IV, Chapter Eight), looking at how women who are mothers of young children understand the term "depression" and how they account for their experiences of everyday life. This incorporates an analysis of the construction of depression as pathology in interpretations of subjective experience.

The notion of subjectivity and its importance in evolving new approaches to psychology, approaches which move beyond the dualist paradigm implicit in the literature discussed in this chapter, is discussed in Chapter Three. A methodological approach is evolved throughout the research described in this thesis, which draws on the theoretical issues discussed in Chapter Three, and which attempts to address the question of how individuals account for and attempt to make sense of their experiences of depression within their accounts. This methodological approach is discussed in Chapter Four and within the context of each study as it is presented.

The aim is to contribute a social psychological perspective to explaining depression, by approaching it as the subjective experience of a person and by looking at individuals' accounts of their experiences within a scientific framework. The methodology was evolved to look at common themes of subjective experiences and at variability between and within individuals' accounts, in an attempt to understand more fully what is experienced as depression within everyday life, how this is experienced and the interpretative frameworks used by individuals in their accounts of these experiences.

CHAPTER TWO: STUDY I. **TALKING TO PEOPLE ABOUT DEPRESSION:** **EXPLORING A QUALITATIVE APPROACH TO** **UNDERSTANDING DEPRESSION**

INTRODUCTION

The exploratory study presented here looks at how depression is subjectively experienced and how experiences of depression may be accounted for among a general population. The study is based on semi-structured in-depth interviews with a population drawn from the university. The study is used to identify initial themes for subsequent research. This included looking at how individuals understand the concept of depression, the ways in which people talk about depression, and what is subjectively experienced in depression. The study was also used to explore the use of a qualitative methodology in investigating depression. While initially based upon a reading of discourse analysis (Potter and Wetherell, 1987) it became evident in the course of the research that this methodology was inadequate for investigating subjective experience, since it emphasises linguistic constructions within the text of the account, rather than the experience of the person giving the account; the text is the focus and limit of the analysis rather than seeing the account as representational of experience. This initial study resulted in a methodological shift away from discourse analysis, and towards the investigation of other methodologies in qualitative research. It also led to the identification of further areas for research: the meaning of subjective experiences of depression, particularly as an experience of an unacceptable self; and the role of a medical discourse in validating problems as depression.

Theoretically the study was informed by symbolic interactionism (Mead, 1934), which argues that the meanings of experiences, events and objects are constructed, internalised and reflected upon by people as they are involved in processes of social interaction, and by Rom Harré's (1972, 1984) work on the construction of meaning within accounts and the use of accounts as the focus of investigation of human cognition. It was also informed by critiques of the notion of the unitary individual and the self as used in mainstream social psychology (e.g. Shotter 1988). These are discussed further in Chapter Three.

This study was used as the basis for further research. Very little work has looked at understandings and notions of depression in a non-clinical population. An exception to this is Rippere's (1977, 1981) work on understandings and notions of depression, but she used a questionnaire based methodology in a cognitive approach which did not

examine individual experiences or understandings in depth at a subjective level. Although much work has considered the causes of depression, using predominantly quantitative and survey methodology, as used in the majority of studies discussed in Chapter One, there has been little work on subjective experiences of depression. Notable exceptions to this are Karp's (1992, 1994) work on patients' accounts of their experiences of depression, looking at illness and identity and using the notion of career in tracing the development of identity, and Jack's (1991) work on women's interview accounts of their experiences of depression. This work focused on the experiences of patients diagnosed as depressed.

Autobiographical writings (e.g. Styron 1990, Plath 1972) which have attempted to describe the experiences of depression, have emphasised the difficulty for persons experiencing depression in communicating how they feel and a sense of isolation and remoteness as part of the experience of depression. Self-help books (for example Rowe, 1983, 1988), using case studies and examples, have addressed the meaning of the experience of depression for individuals and have also emphasised the difficulties faced by friends and relatives in communicating with a depressed person, but they have not taken a systematic approach to identifying themes in the experience of depression using systematically collected data.

PART I DESIGN AND METHODOLOGY

Aims of the study

Overall aim: to explore meanings of "depression" among a university population

The overall aim of the study was to explore individuals' experiences and understandings of depression. Several specific aims were identified:

1. To investigate how people talked about depression.
2. To investigate what, if anything, individuals had themselves experienced which they identified as depression.
3. To investigate the language individuals used in talking about their experiences of depression.
4. To develop a qualitative methodology to look at subjective experiences of depression. An important, parallel aim in this study was to gain experience in using a qualitative methodology, in interviewing, in transcribing and analysing transcripts.

Sample criteria

The aim was to recruit volunteer participants from around the university and the local teaching hospital, to include not only students but a range of staff from academics to cleaners. Ideally, this was to include a range of participants, both male and female, from different social classes, and across the available age range of 18 (first year students) to 65 (retirement age), with a range of different experiences.

It was initially decided not to include psychology students since it was thought likely that they would have been influenced by academic teaching in psychology. However, since the initial response was poor, the sample criteria were widened to include first year undergraduate psychology students. They were beginning the undergraduate course and had received no formal university teaching on depression, they were accessible and it was felt that they might have an interest in the research and so were more likely to take part

Recruitment procedure

There were three procedures for recruitment:

1) Public notices in the university.

A notice was posted up around the university and in the local teaching hospital, in student areas, staff areas and in entrance foyers. This poster was headed “Beliefs about depression” and continued “Volunteers of all ages needed to take part in a study of beliefs about depression and emotions for a social psychology project”, with my name, the address of the psychology department and two telephone numbers in the university on which prospective volunteers could contact me or leave a message. (See Appendix A). Prospective volunteers contacted me by telephone.

2) I made an announcement about the study at two first year psychology lectures and distributed a handout of the notice posted around the university. This was done since the response rate to the initial notices was slow.

3) Personal contacts.

Recruitment through personal contacts was used, as the characteristics of those responding to the university notices became clear, to increase the number and variety of participants and to provide additional participants from among individuals whom I believed may have had experiences of or an interest in depression. Two types of personal contacts were used, personal contacts of my own and contacts through one of my supervisors.

I contacted several acquaintances who were interested in the study, to increase the range of ages and experiences among participants.

Contact through one of my supervisors enabled me to interview a group of pre-clinical medical students later in the study. This was specifically connected to one aim one of the study, to explore themes for analysis in subsequent studies. It had emerged from analysis of the earlier interviews that depression was seen as a medical condition, and one possible future study was of clinicians' understandings of depression.

Prospective volunteers, recruited in these three ways, contacted me either in person or by telephone. I then gave them further information about the study, explaining that it was part of my Ph.D. research on ideas and understandings of depression, and that I was interested in their understandings of depression and any experiences of depression in themselves or others who were depressed. I explained that interviews were informal and that the aim would be to explore their viewpoints. Interviews were to be tape recorded but confidentiality and anonymity were assured. At this point, if they were interested in taking part, I also asked them if they would prefer to take part in a discussion group interview, or an interview with one other person, or would prefer to be interviewed on their own. I explained that interviews would take place in the University Psychology Department and that I anticipated they would last about 45 minutes, and arranged a time.

Sample characteristics

A total of 36 participants were included in the study.

A majority of respondents were students, including 5 postgraduate and 24 undergraduate students, from a range of disciplines. These included one postgraduate with a first degree in psychology, two first year undergraduate psychology students, and a second year undergraduate psychology student. The sample also included one university administrator, a hospital administrator, a member of the academic teaching staff (in an arts department) and a school teacher of psychology. The age range was 18-45, with 3 participants in their 40's, 5 in their mid-late 20's, 5 in their 30's.

The participants were recruited from a general university population. One participant, Ann, described herself as having received medical treatment for depression. Another, Mary, said that she had a long history of depression and was having counselling but she had not received a medical diagnosis of depression, although she believed she was ill. Other participants did not describe themselves as in any way medically depressed.

36 respondents were interviewed in 20 interview sessions, including 4 group interviews (groups of 4-6 participants), 6 interviews with 2 participants, and 10 interviews with 1 participant. This included 3 follow up interviews, one with all the members of one group (5), and two with 1 participant from each of two interviews where the two participants had not previously known each other.

Interview design.

The interview design was informed by the focus of the study, on subjective experiences of depression. Interviews were designed to be as flexible as possible in order to allow participants to express themselves as freely as possible. This approach, which has a long history within sociology rather than psychology, allows participants to express themselves on matters of interest to them rather than those presumed important by the interviewer, (Gavron, 1966), and allows the interviewer to learn the perspective of the participant (Jennings, 1962). Gavron (1966), in her investigation of the lives of house bound mothers, used a schedule flexibly in a fairly unstructured interview in order to discover respondents' own perceptions of their situation. A similar approach has been used here, where the aim was to make the interviews as informal as possible while providing some guidelines and structure for the benefit of both the participants and the interviewer.

The aim in this series of exploratory interviews was to concentrate on the participants' experiences and understandings of depression. This was explained at the start of the interview. In this study, unlike subsequent studies presented in this thesis, there was no interview schedule since the aim was explicitly for participants to generate discussion and for the interviewer to reflect back and pursue the participants' areas of interest. However, I had considered questions to be used as prompts, at least to begin the interview, such as: what does the term depression mean to you? what is your understanding of depression? what do you think people mean when they say they are depressed? These were designed as general and non-specific questions to stimulate discussion.

The aim had been to interview respondents in small groups, so that discussion would be generated by participants within the group and the role of the interviewer minimised. However, in practice it was difficult as interviewer not to take some active role in the group discussion. Therefore I decided to take a minimal role, responding to questions when asked and using prompting questions when necessary to maintain discussion. Some individuals were hesitant about group interviews, although interested in taking part in the project, and so some respondents were also interviewed in two's or on a one to one basis. In interviews with two participants I took a larger role, in attempting to

draw participants out and to ensure that both participants had an opportunity to speak, and in pursuing issues which one or both of the participants initiated. In interviews with one participant I also took a more active role, in asking follow up questions to further explore participants' experiences and opinions.

Participants in interviews involving more than one participant did not necessarily know each other prior to the interview. Small groups were based on the recruitment method used. For example, in one case a group of five students who were friends contacted me and were interviewed in a group. In another, a group of students who belonged to the same student organisation met for the interview having responded to a notice in the organisation's office and were thus interviewed together. Most of them knew each other but they had not volunteered for the interview as a group. I also interviewed a group of three of my own friends who knew each other well and one married couple. I also interviewed two groups of two participants who were previously unknown to each other.

Follow up interviews were also used to further develop issues emerging from the initial interview. For example, one follow up interview included all participants in one small group interview where there had not been enough time to discuss issues raised. Two follow up interviews were one to one interviews with participants from initial interviews where the two participants had previously been unknown to each other, and where it seemed one participant had not been given sufficient opportunity to present their own viewpoint, and the follow up interview offered an opportunity to explore the viewpoint of that participant. Inevitably discussion also covered new areas as these interviews also aimed to pursue interests of the participants as they emerged in the second interview.

The interviews were conducted either in my office or in an interview room in the psychology department. The atmosphere was made as relaxed as possible, to put participants at their ease. Interviews lasted between twenty and ninety minutes. There were three stages to the interview, although these were not in practice discreet stages.

Stage 1. An initial "warming up" process which was concerned with putting the participant and the interviewer at ease, introducing participants and the interviewer. Confidentiality of discussions was emphasised. The use of the tape recorder was again pointed out and I explained that any identifiers were to be removed in transcription so that anonymity would be guaranteed. The tape recorder was then switched on as I again explained that I was interested in participants' understandings, interpretations and experiences of depression.

Stage 2. The second stage was concerned with the discussion of participants' experiences and understandings of depression. This was usually moved into easily from the introduction and explanation of the focus of the study in the first stage of the interview. This stage developed as participants' understandings were explored in more depth and personal experiences and experiences of friends and relatives were recounted.

Stage 3. The third stage was concerned with concluding and winding down the interview. This stage developed as a natural terminating point was reached when it became clear that participants had exhausted what they had to say at the time. Alternatively, where there was a time limit, the last five to ten minutes of the allotted time were used to wind down the interview. Participants were asked if there was anything else they had to add and whether they felt that the interview had adequately covered what they wanted to say. They were asked how they felt about the interview, if they had any feedback on it and on the way it had been conducted, and if they felt there were any problems remaining from it. They were also asked if they would be interested in doing a follow up interview. I ensured they had my telephone number at the university, if for any reason they wanted to contact me later.

The interview relationship

The interview is itself a social interaction and a two way process, or multi-directional if there are several participants. Traditional approaches to interviewing have ignored this, emphasising the objectivity of the researcher, and assuming that the researcher can remain neutral and that to do otherwise would bias the data in some way (Oakley, 1981a). This is to ignore the obvious fact that any interview is an interaction, between at least two people, and that information is given and constructed within the context of this relationship. Within the interview the interviewer and participant interact and are interdependent (Lincoln and Guba, 1985).

The interviewer also has responsibilities towards the research participant, as Berg and Smith (1985) have argued from a clinical perspective. The responsibilities of the interview relationship also have implications for the purpose and motivation of the research. I interpreted these responsibilities as attempting to ensure that the participant did not feel uncomfortable during the interview, as debriefing after the interview to attempt to ensure that it did not cause distress, and as using the data in a way which acknowledged and respected the participant and their viewpoint (see Chapter Ten, Part III, Part C).

I was concerned to minimise the power relationship involved in traditional approaches to interviewing, where the researcher may be seen as some sort of expert and as powerful within the framework of the interaction, and where the researcher's experiences and beliefs are invisible whereas those of the participant are to be investigated and analysed (Harding, 1987). Inevitably, given the focus of these interviews on participants' understandings, the emphasis was on their experiences rather than my own and so in that sense the interview was not intended as a two way and equal exchange. However, I emphasised that I had no expert knowledge on depression, that I was concerned as the basis of my research to look at how participants themselves explained the notion of depression, and that I was not looking for any particular or "correct" answers. I had also decided prior to the interviews that I would answer participants' questions, for example on my own experiences and beliefs about depression, but not to volunteer unsolicited information or opinions. In practice few participants asked me questions, but when they did this was fruitful in generating exchanges and discussion and in developing viewpoints.

I was also concerned that the interview was not perceived as directed but that the participants felt free to express their opinions. In practice this was not always possible since in asking participants to explain something which they had said, to elaborate points, or even in reflecting back through non-directive and open-ended questions (for example, how did that make you feel? could you tell me more about that?) I was inevitably directing the interview to some extent.

Transcription

The taped interviews were transcribed by hand. This was a long process and the first stage of familiarisation with and analysis of the data. The interviews were transcribed verbatim. The focus of interest was the substance of the interview, verbal content rather than detailed linguistic processes, so pauses and stresses were not noted beyond attention to normal rules of punctuation. This was also essential in practice given the volume of data to be transcribed.

Analysis of interviews

It should be noted here that more details are given in Appendix B about the mechanics of developing the methodology in the research presented in this thesis.

The initial stage of analysis involved repeated reading of the transcripts, making notes on the transcripts, highlighting passages, and underlying key phrases or concepts. This was commenced before all the interviews were completed, for practical reasons of time availability.

Methodology was initially based on a preliminary reading of discourse analysis (Potter and Wetherell, 1987). The focus of research in discourse analysis is the text. It is argued that accounts of events are structured through discourses, and that cognition can be approached through the identification of discourses (Potter and Wetherell, 1987; Edwards and Potter, 1992). But through the process of analysis it became evident that a discourse analytic methodology was inadequate for the aims of the project. It was not necessarily consistent with the emphasis of this study on looking at what is experienced in depression, and investigating depression as the experience of a person (see Chapter One, especially Part III). (See Chapter Three, especially Parts I, II, and IV, for further discussion of the underlying epistemological issues.)

Through the process of analysis, a methodology was developed which sought to identify themes in what was experienced as well as discourses, ways of talking about and interpreting those experiences. "Themes" and "discourses" are not distinct but overlapping terms since interpretations of what was experienced are influenced by the discourses used in accounts of experience. (The distinction between themes and discourses is further clarified in Chapter Four). Themes and discourses were identified through repeated readings of the transcripts, in a recursive and cumulative process of analysis. Later readings were informed by earlier readings as the data were reinterpreted, and themes and discourses were more precisely defined and validated. The analytic method developed was based on the following issues:

a) *Individuality*: Within interview analysis.

The approach initially taken was to look at each interview individually, and to identify themes and discourses within the interview. It was felt that the meaning of experiences could be better explored initially on the basis of individual interviews, because the subject matter of interviews was complex and differed between interviews, and the breadth and depth of data both needed to be explored. Themes and discourses were interlinked within an interview and by identifying linkages between themes on a within interview basis, experiences and the meanings of experiences could be more fully investigated.

Points of contradiction were also identified in interviews, on a within interview basis. Contradictions were used to identify underlying meanings and assumptions contained in accounts. Contradictions were evident in all interviews.

b) *Commonality: Cross-referencing across interviews.*

The identification of themes was a cumulative process. Although interviews were analysed individually, there was constant process of cross-referencing by the researcher. Themes which were developed strongly in one interview might then be identified in subsequent analysis of other interviews, since once a theme had been identified it was more likely to be recognised if present in other interviews. Cross-referencing emphasised the commonality of themes between interviews.

This was incorporated into the second stage of analysis, which moved beyond the analysis of individual interviews. The themes identified within individual interviews were pooled. Links were identified between the themes and, as this led to the development of new perspectives on some data, some themes were restructured. An emphasis on both the commonality and variability of experiences was developed in the analysis.

c) *Validation of themes:*

The aim was to validate the analysis with reference to the data. On a within interview basis the aim was to validate themes and discourses throughout the interview transcript which were consistent with the overall meaning or interpretation of the interview and which were supported by several extracts throughout the interview. While extracts could be subject to multiple interpretations a valid interpretation was accepted as that which was consistent with, and constructive in, the interpretation of the interview as a whole. This sought to guard against the selection and interpretation of extracts out of context. Validation was thus ensured through a recursive analytic process, whereby themes identified were consistently validated through rereading data and through the extension of analysis as more data was analysed.

Conversely, contradictions were noted as part of the complexity of the account and as part of the analysis. Contradictory themes and discourses were used to explore assumptions underlying the account.

Validation was achieved by initially looking for coherence of a theme throughout the interview, and validity of themes within the structure of the interview as a whole. Initially the aim was to achieve some sort of coherence within an interview by building up themes from the data and by looking for themes which were repeated throughout the interview.

However, and at the same time, themes were further informed by and developed in the light of an across interview analysis and the final themes were validated in the light of the analysis of the body of data as a whole.

PART II RESULTS.

The first part of the results section will look at how individuals described trying to communicate and explain their experiences of depression to others. It uses a discourse based approach, and the problem is seen in terms of the non-availability of discourses which encompass the experience of depression. Individuals described feeling misunderstood when depressed and isolated by the reactions of those around them.

The use of a medical discourse, in the identification of depression as an illness and as a condition needing specialist medical help, will be examined in Part B. The medical discourse has important functions, given that individuals find that their experiences of depression are misunderstood, in validating individuals' experiences as real problems, in offering a recognition which is not otherwise easily available and in offering the hope of explanation and resolution.

The subjective meaning of the experience of depression and implications for the construction of self are discussed in Part C. Depression is a personally meaningful experience, which is experienced as outside, distinct from or beyond everyday social experiences. It also involves a sense of loss, of being cut off from the social world.

The questions of how depression was described, in terms of feelings of being out of control, and how the experience of depression is linked to concepts of power, agency and responsibility, will be examined in Part D. Here depression is discussed with reference to ideas of empowerment and as an experience of powerlessness in relation to others and to oneself.

Excerpts from interviews are presented and discussed in this section as examples of the themes and discourses identified. Pseudonyms are used throughout the thesis to protect the identities of participants in the studies. It is worth noting at this point that only Ann had received a clinical diagnosis and treatment for depression.

PART A: EXPLAINING TO OTHERS/ BEING MISUNDERSTOOD

Part of the problem of depression may be feeling misunderstood. It seems that part of the problem of communication is the need to give a reason for emotional experiences within the framework of everyday discourse, as a validation of those experiences to others and to oneself. Part of the problem for individuals who feel depressed is that they can give no reason. Part of the experience of depression may be that there is no evident or easily identifiable reason for how one feels and that this makes it difficult to account for depression to others and also to oneself

1. Definitions of depression

1.1 Depression a distinct state, an illness

There is no language available with which to easily distinguish the experience of severe depression, in particular from more common, everyday and apparently less severe experiences of feeling depressed. Ann, who had experienced severe depression which she described as an illness, distinguished this from more common experiences which, she implied, the terms "depression" or "depressed" were used to describe within popular discourse. She believes her experience of depression is different from that meant, for example, in everyday use of the term "I feel depressed". She implies that "real" depression is an illness.

Ann: Depressed or depression is such a widely sort of misused term and it's very difficult and there's not really another sort of word, you know, people use the same word for both different, you know, very different kind of states.

There is no easy way of differentiating experiences: that of severe depression is often understood as merely fed up unless labelled as illness. Ann distinguishes it by talking of it as an illness.

Ann: Someone says, oh I'm feeling depressed... One will be as you're saying sort of fed up for you know. And somebody will be really, you know, ill ill.

People are not likely to use the term "depressed" when severely depressed. The implication is that this is a term covering less severe and more common experiences of feeling down which does not convey the difficulties of "real" depression.

Ann: If someone goes around saying, ooh, I'm really depressed you know it's kind of, you can say that well it's guaranteed they're not kind of thing.

1.2 Depression as unhappiness

David suggests that feelings of depression cover a range of experiences. He suggests that depression is a reflective experience, a realisation of how one does feel, for example unhappy. He thus defines it in terms of everyday emotions as well as more psychological concepts, such as self-worth, through which depression may be explained. (However, it was also evident throughout the interview that he saw depression as a very serious state, which could be understood as an illness and not only in terms of common feelings).

David: Depression isn't just about guilt and self-worth and that sort of thing, it's as much about suddenly feeling, well, I'm just not happy.

Tim also constructs depression as being unhappy. He further elaborates this since he defines happiness or depression as a relative social state, measured through social comparison and related to the social context. Knowledge of the social context is incorporated into subjectivity. (See discussion of Anthony Giddens' (1979) theory of structuration, Chapter 3, Part II, section 6).

Tim: The movement towards happiness or depression, even if it isn't caused by your place in the context, will be easier to measure it by, against that context.

1.3 Common understandings of depression

Tim and John, in a joint interview, agreed on a popular understanding of depression, that the world seems bleak, pointless and that there is loss of motivation. They conceptualise depression in terms of how the individual understands or experiences their world, as a subjective experience.

John: A common held view of depression. It's just that everything's bleak and just, just, just pointless. Shall I bother doing this, the negative outcomes are-

Tim: Yeah, I think no, absolutely no motivation to do anything.

2. Describing the experience of depression/ communicating to other people

Mary reinforced the point that depression is difficult to describe because there is no language available. She suggests that depression appears like pessimism, and so people react to her as if she is being pessimistic. This is totally inappropriate since the experience of depression is qualitatively different to feeling pessimistic. It is an overwhelming experience which takes her over, it is more than feeling sad, is not specific, and it includes physical symptoms.

Mary: It's just not like being very sad, it's just like the worst thing in the world, it's, it's like everything comes on top of you, everything in the world

seems negative, which, just, people just like, it just looks like being pessimistic, and say don't be stupid, you know... you're good at this, that... why aren't you happy kind of thing. And there's so many physical symptoms, it's just like a whole, um, just one kind of, like, mass of horror really.

Mary suggests that the experience of depression can only be taken as a whole, rather than categorising aspects of it in everyday terminology which fails to convey the complexity of it. It is an experience set apart from the everyday and its horror cannot be encompassed within everyday language. Mary suggests that she is trapped *within* herself.

Mary suggests that depression is not something which can be explained to other people, since language cannot be used to explain it, and that depression is only meaningful in the light of prior knowledge or experience. This indicates that, if depression is a subjective experience which cannot be understood by others, the problem may lie in how depression is accounted for to others, and interpreted by others, and how it is constructed through language (the focus of the research in this thesis).

Mary: Its completely futile talking to someone that doesn't know you're talking about, its, you might as well be talking in Hebrew or something.

In depression Mary is trapped within herself, in a highly emotional experience. Depression is something which is out of her control and which she is unable to rationalise. People cannot understand that she is unable to control herself or her depression, that depression is something which happens to her and takes her over. In the excerpt below and elsewhere in the interview she suggests, when describing people's reactions to her, that they think she has a choice in how she behaves.

Mary: When you get in that state you're totally out of control, you're less aware of what's going on... And that's what people find difficult to understand, that, er you can't rationalise it, you can't just calm yourself down, it kind of, it just, um, expands in your head and you can't, you can't, er, just snap out of it.

Mary believes that people do not understand the ways in which she deals with depression, for example by avoiding situations she knows she will find problematic. She, on the other hand, predicts and takes account of their probable reactions and attempts to see the problem from other people's point of view. Coping with the experience of depression means taking other people's perspectives into account. She is aware of the discrepancies between her feelings and how she appears to others in social

situations, and actively attempts to avoid these discrepancies becoming markedly apparent.

Mary: You know if you're in a social situation you have to think how are they going to react and what its going to be like.

So she avoids certain situations but says that, seeing as there is nothing obviously "wrong" with her :

Mary: People don't see this as me trying to be practical about it, they think you can control your er thoughts.

Depression only seems irrational, and there are reasons for her experiences of depression rooted in her own life history. But these are so complex that she herself cannot unravel those reasons and they are not something which she can explain either to herself or to others. She believes that people need a reason in order to accept how she feels.

Mary: They want a reason, you know, they want to rationalise it, they want a reason why you feel like that at that moment and there isn't necessarily. There probably is but it's so deeply, it's like it's all so deep and complex you can't like unravel it you know.

Depression cannot be explained within a discourse of rationality, which it is here suggested is powerful in accounting for emotional experiences in terms acceptable to others. But the failure to account in such terms means that the individual may be seen as irrational by others.

3. Denial and avoidance of depression by others

Ann suggests that people do not understand the significance of depressive behaviour. Behaviour is interpreted in terms of normal patterns of interaction, and people are not aware that the behaviour of depression indicates a qualitatively different subjective experience.

Ann: I mean, if you're really bad people just don't really understand, because to the extent at which you're staying in your room all the time and just doing this and doing that, people just get fed up... people don't pick up on that this is a bit different from er, what usually is going on.

However, David goes further and suggests that people actively deny depression. They do not want to recognise it in someone they are close to, since that would mean acknowledging their own involvement in that person's experience. Difficult emotions can be avoided by a person's family through their denial of the person's experiences of

depression. (He referred throughout the interview to his sister's experience of depression and to his mother's feelings surrounding this.)

David: So therefore people who are nearest sometimes will want to deny there is anything wrong. Because, like you say, it could be that they're involved in this... according to that person's development as a child... all these issues which are highly emotionally charged.

4. Recognition and validation by others

Ann sees the best form of help, for someone who is depressed, as accepting what the depressed person is experiencing, so reducing their fear and isolation. Validation of problems is seen as important in helping to cope with the experience of depression. She argues that helpful behaviour is to:

Ann: Sort of agree with them a lot about feelings, see that it wasn't too, you know, too weird or frightening... sort of give company... and just talk about other things. Just try to sort of get a bit more sort of normality back sort of thing.

The denial or rejection of the validity of depression may be experienced as a denial or rejection of self. For Mary, the denial of how she is feeling, by other people who refuse to accept it, amounts to a denial of her integrity. This for her amounts to a denial of self.

Mary: If people just um deny um any existence of integrity or intelligence on my part... that is the most frustrating thing of all.

David argued that part of the problem of depression was being misunderstood and the denial of the person by others, who refuse to accept them for themselves and in their own terms and who criticise them.

David: That's where I think lies a lot of the problem for people, accepting people for what they are, for what they're experiencing, rather than saying, look, pull yourself together.

For David, however, part of the problem in being with someone who is depressed is that they assume he cannot understand what they are experiencing, which they cannot express, and that this sets up a barrier between him and them.

David: There still seems to be something, which, they believe, any outsider doesn't believe it, doesn't understand, and they find it difficult, or impossible to um, um, express what they feel.

Ann suggests that other people may attempt to trivialise or rationalise the experience of depression. The person feeling depressed may then feel misunderstood, and there may be a barrier to communication.

Ann: As soon as you start saying to somebody, well, look, this isn't going to last, and this isn't how it is, and then they start to shut up on you a bit because it's immediate, oh they don't understand.

It is significant that Mary describes feeling understood, with friends who have had similar experiences in their families, as an "unspoken kind of understanding", which is also "something I realised afterwards, you don't necessarily talk about, they just know". It is an intuitive understanding based on a common experience. This also suggests that depression is a common experience, although also a highly personalised and subjective experience, but not one which can be conveyed in language.

5. Rejection and fear

David suggested that people do not want to recognise depression nor attempt to understand it. Instead they deny its existence. He is drawing on his experience as a medical student and his experience of his sister's depression. He sees doctors sharing general social attitudes in denying depression.

David: Yeah, nobody wants to see it's there. I wouldn't say nobody but a lot of, yeah, people, particularly, um, particularly um, dare I use the word lay, people. To the lay person, I could even class a doctor as a lay person because there's a lot of unsympathetic doctors... Let's just say a lot of people deny it exists.

Thus what results is not understanding but rejection.

David: Because if your depressed and I can't cope with it I cope with it by rejection.

The idea of rejection of parts of one's own experience is used to explain attitudes to mental illness in general. These attitudes are explained through fear of those same experiences in oneself.

David: Quite often in a lot of mental, mental illnesses you see things in people that quite often resemble what you have experienced or are experiencing at the time.

Depression is seen as lying within most people's experiences. For David it is:

David: An exaggeration of what, er, everybody experiences at some time.

But people reject experiences within themselves because they want to be accepted and depression is seen as abnormal:

David: People want to be accepted and anyway you feel yourself deviating from the norm, you are really going to do everything you can to prevent it being revealed"

Mary explains that people do not understand, or do not want to understand, depression because of their fear:

Mary: I think it [depression] frightens people.

There is a denial of the idea that depression is a categorically different or abnormal experience. A person who is experiencing depression may be rejected by other people but this rejection is explained by the shared and not the uncommon features of the experience of depression. This may be why depression is usually placed outside the limits of everyday social discourse.

6. Depression is a problem for specialists

David suggested that people avoid the difficulties associated with depression, expect a reason and solution for it, and see it as the province of medical specialists and experts. He argues that social attitudes to depression have been shaped within general social expectations of the explanation and solution of difficult personal problems by scientists, and particularly by doctors. A scientific discourse is powerful within popular culture, and is seen as minimising personal responsibility.

David: It's moving in an age where we expect answers and we expect explanations... because we feel that, um, development, progress, it's moving apace in so many other areas.

David argues that people expect problems to be resolved as reasons are identified for them and acted upon. It is the expert's responsibility to find the solution, not individuals' to work out problems themselves. People are looking for:

David: Tangible, very physical direct things they can see and do rather than work through themselves. 'Cos they always feel the ownership is someone else's".

Problems are conceptualised in terms of an emphasis on the physical, the explicable and the rational, and as requiring answers from experts, within a scientific and bureaucratic culture. Thus the experience of depression can be further distinguished from everyday social experiences, and the responsibility can be shifted to experts.

PART B: THE MEDICAL DISCOURSE OF DEPRESSION

1. A liberating discourse

The recognition of depression, as an illness, is characterised in this analysis as a medical discourse of depression. This may be experienced as liberating. (See Chapters Five, Chapter Eight, Part III, and Chapter Nine for further discussion of this). There are moral implications of defining depression as an illness.

A friend, by suggesting that Mary was ill, offered her an alternative way of understanding her experiences and the hope of resolution (which is not fulfilled). The identification of her problems as real and their acknowledgement as an illness meant that Mary no longer felt that she was to blame. The idea that she is ill potentially absolves her from self-blame and personal responsibility. The recognition of her problems also empowered her to try to resolve them.

Mary: It was one person when I was sixteen telling me that I was actually ill, and no-one had said that before, and someone else just saying that I was ill, that it wasn't my fault you know, everything had gone wrong but I mustn't- it gave me a totally new aspect on the way I was and I thought if I could understand it... I'm sort of really genned up on where it comes from, and looking at it objectively and, um, and, um, and it's still there, you know.

She experiences the recognition of her problems as real and as illness as personally liberating, since it also implies that she has some importance and validity as a person.

Mary: I started wondering if everything in the world wasn't my fault really and er maybe I had some sort of illness... but I didn't think I was important enough to have anything like a serious illness.

2. Depression as a breakdown in function: an acceptable problem

David developed an approach to depression which can be broadly characterised as medical. He understood the person suffering depression as free from personal blame. Depression is seen as a breakdown in function for which the individual cannot be held personally responsible, and which is out of the individual's control, in the same way as a breakdown in physical function. Thus depression should not be stigmatised or feared. David sees this as challenging common experiences of depression as something the sufferer is in control of and which is their fault.

David: Most people see depression as something very, very frightening... which is their fault and they are in control of... rather than accepting it as a

breakdown in normal function, like a breakdown in normal function in other areas of your body.

He does not see depression as a categorically defined condition though. There is a problem in identifying when depression becomes a serious medical problem, which needs treatment, rather than a symptom of everyday living. He does not see a categorical distinction between depression as an illness and as an everyday experience, in terms of the abnormal and the normal. "Normality" is constructed in terms of social conventions and not as a scientific, objective definition.

David: When does things like anxiety cease to be a normal symptom of everyday living, er, become a serious symptom which needs treating? Because everybody knows what anxiety is and I think everybody knows what depression is.

David: All the symptoms of depression are exaggerations one way or another of normal symptoms.

David: There isn't a normal. I mean. It's, again, it's, that's all about social conventions, isn't it?

3. The stigma of mental illness

Mary is in a contradictory position. The identification and validation of her experiences as a depressive illness would enable her to justify her behaviour and to gain recognition for her efforts in coping with depression. Yet she is also aware of, and wants to avoid, the stigma of mental illness.

Like David, she makes analogies between mental illness and physical illness. Physical illness is something which happens to someone, which it is accepted that they cannot control. But she believes mental illness is stigmatised, because without the physical evidence people do not accept that it is real, and do not respected it as a real problem. Instead they see it as a problem in the individual, as imaginary and as something which the individual should control.

Mary: I just wish people would see mental illness in, obviously its not the same... but with the same kind of respect really... I think anything in your head its like, um, you're only imagining it.

A label of illness which had a meaning similar to physical illness would legitimate her depression. The label of mental illness is inappropriate since, as it is commonly understood, it devalues and stigmatises her meaningful subjective experiences. She understands her depression as a rational reaction to experiences in her life. The problem

of the clinical term "depression" is that within popular discourse it constructs the person as pathological, uncontrollable and deficient (Karp, 1994).

PART C: DEPRESSION AS AN EXPERIENCE OF SELF

Subjective meanings, experiences of depression and their implications for the construction of self are discussed here. Accounts of experiences of depression suggest that people experience themselves in diverse ways in different social contexts, that the self is multiple and not unitary, that the experience of self is dynamic and not static and that experiences of self may be contradictory. Accounts indicate that the self is constructed through relationships. It is rooted in biographical and historical experiences as well as constantly reconstructed according to the moment of experience. (As in Anthony Giddens' (1979) concept of "durée", see Chapter Three, Part II, section 2.2. These issues are discussed further in Chapter Three, Part II, section 2, and Chapter Three, Part III, section 2.1.)

1. Individuality, feeling different from others.

Depression may be constructed as an experience of an unacceptable self, a feeling of being cut off from others. Ann, in reflecting on her experiences of depression, relates depression to a feeling that she was different from other people. She says that since she no longer feels different from others she does not think that she is likely to become depressed again. This suggests that depression is not only different from everyday experiences but that it is related to a sense of feeling cut off from and different from other people.

Ann: I think part of the reason I don't think I will become ill again is because I don't particularly feel as though I'm different from anybody.

The sense of difference is also a sense of being special, of individuality. A person may invest their identity in a sense of difference, and apartness, and become dependent for their construction of self on the sense of distinction which depression gives them.

Ann: You're sensitive enough to feel all these things and... I think you get kind of hooked on that... it's sort of something to do with your own individuality.

2. The "real self", distinct from everyday social experiences

Mary suggest that she experiences feelings of depression at a different level from, and as underlying, other social experiences:

Mary: You have a good conversation with people and you go home and that, that can be completely sort of not relevant to the underlying feeling.

She suggests that the experience of depression is an experience of a self distinct from and apart from others. In experiences of depression there are underlying feelings which are distinct and separate from current social interaction. This suggests that the experience of depression is distinct from everyday social experiences and that it is a different quality of experience. She suggest that it is something which she experiences on her own and in isolation.

Ann, reflecting on her experiences of depression, suggested that her social experiences were relatively superficial and meaningless. Her experiences of depression on her own incorporated emotional experiences at a deeper level, and a more real awareness of her feelings:

Ann: You do I think feel kind of closer to yourself, or closer to, er, to, to certain, to certain emotions and things. And th', that's, I mean that's the feeling of it, that your day to day life is just like really superficial and, and a real sort of you know sham if you like. You're down the pub and having a laugh and its just so meaningless, that you know, sitting in your room and brooding seems to be more, you know, more real and less sort of superficial or whatever.

Ann: You can kind of feel closer, closer to things or closer to what seems real to you.

There is strong implication, in these descriptions of depression as a personalised and subjective experience, that Ann experiences her real self when she is alone, and that at other times she is not her self. This suggests that depression is experienced not so much as a loss of self, as argued by Oatley and Bolton (1985), but as recognition of a real self, but only when one is alone, and apart from the social world. Depression is not a choice not to integrate or interact with others but is an experience of a real self which is apart from everyday social life.

Experiences of depression are meaningful. There may be important aspects of subjective experience which are not integrated with, or connected with, but are divided from everyday experiences and which are highly meaningful to the individual.

3. Difference from normal everyday experiences

Ann suggests that depression is a qualitatively different experience and one which is difficult to recall when she is not depressed:

Ann: It's very, very difficult, it's like talking about a state which you just virtually can't remember it, cause it's such a different way of perceiving everything. And as soon as, as soon as you're, you're sort of not in that state you really can't remember just how awful it felt to be like that. And when you're depressed you really can't remember how, you know, fine and normal everything can be when, you know, you're feeling alright.

The experience of depression is valid and real at the time. There is almost a feeling of being at home in depression:

Ann: It can feel almost more normal than er, when you're fairly happy and content.

4. Depression is a subjective experience

Depression may be understood only on the basis of subjective experience. For Mary it is part of herself, and part of her life experiences. It is not a state which can be objectively identified. It has meaning for her in the context of her life history, which is intrinsic to her and can only be understood in the context of her experiences:

Mary: Bad times and bad experiences... and you can't just like block it out, you have to cope with it, it just effects the way you are, you can't just like push it to one side, it, it's just innately part of what you are and your experiences and the way you think and, um, when people try to be so black and white about it they just don't respect my integrity.

Mary believes that it is impossible to generalise about depression since it is a highly subjective and personal experience. Nor are there any general solutions. She believes that depression is not a common experience across people but one which is individually meaningful. She bases this belief on her experiences of other people who do not understand what she experiences when she is depressed, and her difficulties in explaining her depression to them (which was also her motivation for participating in the research).

Mary: You can't just compare it to another case and say this person acted like this and this person got cured like this because it's, um, a completely different set of values, it's a completely different personality, you can't just put a list of, er, you know, a list of things, just apply it to the person, and see if it works.

Ann had experienced continuity in her own experiences of depression but believed that experiences might differ between people:

Ann: I think I've always felt fair', fairly much the same kind of things on each occ', I mean very, very similar kind of things, so I couldn't really say what anyone else would feel.

This leaves open the question of who can understand experiences of depression: is it the health professionals who treat depression? (See Study III, Chapter Six)

5. Making sense of depression

The experience of depression is one of being out of control and overwhelmed, as shown earlier in this analysis (Part A, section 2). Mary, for example, had tried to examine reasons for her experiences of depression as a way resolving them. But this has not been successful and has left her feeling more frustrated:

Mary: And now I know exactly all the reasons and I know how things happen and it's just more frustrating. Only I, I just get really angry about the way things have turned out, the way things happened and it's sort of, like, made me more het up about it in a way.

The fear of depression is located in the belief that it is an irrational experience. Ann suggested that the fact that there is no external reason makes it worse:

Ann: I mean the whole point is that you're feeling really bad and in a sense you're, it makes it worse if you're aware there's nothing major causing it.

Ann fears the return of depression because it is an irrational state, where she is at the mercy of unpredictable and uncontrollable moods:

Ann: If you have ever been in that state, it's like a real fear it's going to come back. And that's part of the thing because it does not seem particularly externally controlled. So it's kind of, it's kind of like a fear of your own irrationality, of your own moods, that that's going to happen for no sort of really good reason, you know, whatever that could be.

Responses from others, attempting to rationalise her experience for her, also worsened the experience by emphasising its apparent irrationality. For example, when people "show you the absurdity of thinking **that** could be so awful", that, for Ann, was an unhelpful reaction.

6. Remoteness and isolation

David quoted his sister, who described her experiences of depression as feeling that she is unable to make contact with other people. Depression is an experience of loss, and he reported her as saying: "I feel as if I am so remote from people and that I am losing out because I am trapped".

Tim, when asked for an image of depression, described it as isolation, remoteness, and a feeling of being cut off and apart, and unable to reach for the things that he needed. It is an experience of remoteness and frustration:

Tim: My image of depression, and this is probably not a generalised one but I'll advance it as a personal one, is um, you know these sort of old hermits that used to live at the top of a pillar. Well, I would say, you know, that that would be the individual being on top of that pillar. And he'd sort of be surrounded by um things that were, could be fulfilling of needs or wants but not able to... you know, contact them, use them.

7. Others' views of self

David identified a problem in how people are perceived by others, which occurs when people become depressed:

David: When people do get depressed... you do find they have a lot of problems with, um, how they are and how they are perceived by other people.

A theme throughout Mary's interview is the gap between the way she feels and the way she experiences her relationships.

Mary: Like the way you are and the way you relate to other people... doesn't always match up.

This leads to her questioning herself, and to self-doubt:

Mary: No matter how much you think of yourself, if you don't get the same kind of relation to, with other people, then you start to wonder if you're, you're, you're doing something right.

8. The unacceptable self

Mary experienced herself as unacceptable to others: she does not feel that they see her as she sees herself, that they accept the ways she experiences herself.

She traced the roots of her depression to the way her "self" was constructed by others. She experienced herself as unacceptable because she felt rejected by her family:

Mary: You know, you grow up being taught what's right and what was right was that I was wrong all the time and, like, I was wicked and horrible and, like, now I've, I know I'm not.

Mary has to negotiate her sense of self in her present social context, which actually denies her past experiences and feelings. There is a tension and contradiction here between past and present: her past experiences of being rejected by her family are denied in a better present, where her friends accept her for what she is, and experiencing herself as acceptable to others is a feature of the present which was denied to her in the past. She may be trapped in and unable to resolve the contradiction between her self as constructed through past relationships and her self as constructed in present relationships.

9. Asserting self: a way out of depression

The experience of depression can be understood as an experience of powerlessness. For Mary, part of the problem of the experience of depression is that she feels powerless, and this leaves her very vulnerable in relation to others. It traps and marginalises her.

Mary: You're like in a vulnerable state and so the other person is in, like, higher status.

Friends who recognise Mary's right to be angry are instrumental in legitimising that anger, and this in itself becomes a source of resolution.

Mary: They can see I'm angry and they can see it's positive that I'm angry about it.

In Mary's account of her experiences of depression and her attempts to communicate about them, there was a tension between the belief that no-one else can understand her experiences of depression and her need for other people to accept her experiences and to back up her reactions, and between her distinction of an inner self-contained experience of depression and her experiences of validation of her social behaviour by others. Although Mary claims that there is a gulf between her and others she has also negotiated some bridging points with friends who do accept and support her.

She needs these bridging points to come to some sort of resolution of her own experience. For Mary, anger towards others who are dismissive of her is:

Mary: A real step forward from just accepting what they say, just like being dragged down, if I stand my ground that's really positive.

Anger enables her to cope with her experience by standing up for what she feels, in the face of opposition by others. This also applies to enabling her to validate her experiences of depression.

David believed that one way of avoiding becoming depressed is to find out what one wants and assert one's own needs:

David: Finding out what works for you and having the confidence to pursue that.

In talking of his own experience as an athlete and the social pressure of having to achieve in athletics, he said that such pressure can be a trap which leads to depression. In talking of friends in athletics he said:

David: People turn round and expect them to put more effort in, to, to go one better, 'cos we're never satisfied. And so from that point of view I can see where people get trapped in that. Because I've been, I've nearly experienced that.

This suggests that a problem may occur when the individual is trapped within the expectations of, and pressures from, those around them. One way to counteract and resolve experiences of depression may be to stand one's ground, and assert oneself against such pressures. But as suggested by Mary, once depressed this is very difficult because then one experiences oneself as powerless in relation to others.

PART D: AGENCY, POWER, CONTROL AND RESPONSIBILITY

Depression was conceptualised in terms of feeling powerless to control oneself. Some participants had well developed models of depression, and these varied between individuals, including explanations of depression as a biological process, explanations of depression as a problem located in the mind and in thinking, and explanations of depression which related depression to social issues of power and responsibility. Thus depression is seen as a problem located in the individual and as a problem located in the wider social context. It is seen as a problem which the individual can control, and a problem which individuals may resolve if they accept that have relatively little control over their lives but identify those areas where they can exert some control.

1. Depression and mind

Firstly, in a biological/organic and reductionist model of mind depression is seen as uncontrollable by the individual. Drawing on a biological type model, depression is also seen as a reaction to stress.

1.1 Depression located in mind

David understands depression, in contrast to the non-depressed state, as:

David: Somebody gets themselves into a situation where they feel totally helpless.

Depression is located within the mind and the individual is understood as trapped within their mind. This mind is mysterious, and contains the person.

David: There are entities in the mind that don't, that that will not let these people out.

David develops this in terms of a reductionist model. Mind is understood through analogy to the human biological system. The individual should not expect to be able to control their mind because it is going out of order. Depression should be accepted, like physical illness, as a loss of control.

David: Just like they couldn't control the heart if it was going out of order, yeah, the bowels. Why not accept that your mind's going out of order.

David defines depression in terms of feeling helpless and powerless. But he also validates the problem of depression as acceptable through analogy to physical, or non-mental, illness.

1.2. A stress model of depression

Depression is understood as a natural process, over which the individual has no control. John developed a biological type model of depression as a reaction to life's pressures, as bringing relief from those pressures in a "sort of wash out process". Depression is a natural base state which an inbuilt optimism mechanism lifts the person out of. Problems occur when this mechanism fails and the individual is helpless to lift themselves out of depression; at that point they might need outside help.

John: These pressures build up and there, there's this kind of wash out mechanism and de', and depression probably part of that. All your body systems are depressed and you have to flush this out and you rely on this, on this optimism mechanism to kind of lift you out again. Then you can start the cycle again... But it's when you get too extreme that you're, you might, you know, need help.

2. The mind as agent: personal power

Secondly, a model of mind as agent is used, and the individual is said to be able to combat depression through their own power in thinking positive thoughts. The problem of depression is again understood in broadly cognitive terms.

2.1. Reasserting control of mind and regaining personal power.

Carol, who practised meditation, argued that her way out of depression was discovering her personal power in her ability to have positive thoughts. Through this she can redefine experience in more positive terms, she can change her behaviour and she can influence her world. She has experienced herself as able to actually change situations.

Carol: It is a gradual process of discovering that I am powerful and that this powerful being is able to have powerful positive thoughts. That affects me, it affects my relationships and that actually gives me self-respect. Someone can sit here forever and say you're powerful, you know, you're positive, you're all these things but I'm not going to believe them unless there's a reality to it. In other words, unless it can do something. But when I use this it does something, it actually transforms the situation.

2.2. Mind as agent

Carol constructs mind as the active agent within herself. She constructs a reflexive model where the mind is seen as attacking itself. She believes that depression occurs because of a preponderance of negative thoughts, and sees this as an attack of the mind on itself. Self-critical thoughts are conceptualised in terms of a physical metaphor of attack.

Carol: That's when depression can really set in, because the mind starts to attack itself and when it attacks itself it can really knock the confidence out of

you, and then you do something that goes wrong, you know, and you get into that cycle and all your confidence goes.

Janet, in the same interview, criticised this understanding as limiting and containing the problem of depression within the mind. She suggests that the notion of "mind" works as a metaphor which in turn shapes understandings of depression. It implies determinism in contrast to notions of personal responsibility and control.

Janet: I think that if you are going to use this mind model then you will always be using this kind of content container metaphor and you wouldn't have any choice about it.

In other words, the problem of depression is located within the individual's mind. She suggest that this is in fact a disempowering model, because it makes depression a problem of mental efficiency and limits personal agency to mental effectiveness.

Janet: You're using a very characteristic mind as agent model, um, mind producing thoughts, do thoughts go through to action or whatever... in a sense the kind of model that would make something like depression a trap, because it does locate your personal agency, um, within a sense of um, um, mental effectiveness.

The model of mind as agent removes the social significance of experiences of depression, since depression is explained as problem contained within the individual. Depression is conceptualised in terms of mental processes.

3. The social significance of depression: social responsibility and personal power

An understanding of power and responsibility within social and cultural contexts is used to identify social and cultural problems, to look at areas where individuals do have power and to look at the limits of individual responsibility. This was linked to taking a feminist position by one participant, Janet, since it moves the problem of depression from the individual to the social; the problem for the individual becomes one of recognising the limits of their power and responsibility within their social context.

For Janet, the experience of depression has social and cultural implications and it is vital to see it within its social and cultural context. This is essential in order to understand the significance of the problem of depression, to prevent people taking undue responsibility for things over which they have no control, and to enable them to see the causes of their problems as social and cultural rather than as personal failings. But it is impossible within the terms of a model which locates the problem of depression in the individual.

Janet: If you know that these things have an effect on you, on how well you operate, then you've got the kind of description that actually does help you define areas of responsibility. And that can actually help in thinking about behaviour on a broader social basis. I suppose I'm thinking about this in a way that links with the notion of being a feminist in that, you know, what you want to be able to do is to help other people, you know, not to take undue responsibility for the state they're in given the cultural conditions in which they're living.

Rather than looking simply for causes of depression Janet has aimed to empower herself, through attributing problems more correctly on both a social and a physical level. For example, taking exercise has a beneficial effect on how she feels, which can be explained at a biochemical level, but also gives her some control over her feelings:

Janet: What happens if you, if you work physically very hard at that, um, point is describable in mechanistic terms. You know, it would be describable in terms of balances of chemicals in your body... I would see it as at a very, very primary causative level.

4. Powerlessness and adjustment

John links depression to a view of human experience which is of relative powerlessness, and believes that the recognition of powerlessness can be instrumental in resolving depression, when powerlessness is recognised as a common and inevitable element of human experience. Depression is linked to social experiences and the realisation of self-efficacy through social comparison:

John: Getting out of it is realising that in fact we are all powerless to a certain extent.

For Tim, suicide is seen as a logical outcome, a feasible adjustment, to deprivation which the individual is powerless to change.

Tim: If depression arises from deprivation of certain things, whatever they might be, if you're permanently deprived, and however far you're able to adjust it isn't far enough for your own perceptions.

Ultimately even suicide is seen as an adjustment. This is the ultimate conceptualisation of depression as powerlessness, when self-destruction is seen as the only feasible response.

Tim: If the person who's depressed sees it as unadjustable to, maybe suicide is an adjustment.

The problem of adjustment is located in the individual's mind and is presented as an intellectual dilemma.

Tim: If there's certain things that can't be adjusted to intellectually then how do you cope with them?

PART III DISCUSSION AND CONCLUDING POINTS

1. Emergent themes in account of depression

Themes in accounts of depression which have emerged from the interviews reported in this exploratory study include: the difficulty of communicating about depression; being misunderstood; depression as an experience of a different self; and depression as an experience of powerlessness. These have suggested that depression is experienced as a sense of apartness from the social world. This experience could be characterised as the experience of an unacceptable self.

1.1 Feelings of apartness

Individuality may be invested in a sense of distinctiveness from others. This operates at several levels. For example, Mary had to plan her life around the threat of depression, and also saw her experiences of depression as an intrinsic part of herself. Depression is incorporated into her life at the level of structure and routine as well as into her sense of self and identity. Ann suggested that the sense of difference and distinctiveness from others experienced in depression is itself valued by the depressed person. Depression is a real and meaningful experience. It is not chosen but is a real problem which affects the individual's sense of self and their experiences in social relationships.

1.2 Being misunderstood.

Individuals might be seen as constructively coping with their experiences and as showing strength in coping with very powerful emotions and situations. But conversely they might be seen by others as weak, because they were vulnerable and not able to control depression, and their difficulties and attempts to cope with a very difficult problem were not recognised.

Discourses available to construct accounts of experiences of depression were limited. People who were depressed felt unable to express themselves. This could also be seen in accounts of depression as seen in others, since here depression was described as something which was puzzling, which observers felt that they were unable to understand. Individuals felt misunderstood and there were no discourses readily available with which they could interpret their experiences.

Some discourses might be more powerful than others in talking about depression. An example of this is the use of the medical discourse, of depression as illness, to validate the problem, and to gain recognition from others. However, at the same time this was pathologising and might be seen as inappropriate. There was ambivalence as to how it

related to the subjective experience of depression and contradiction in its use: individuals both used and rejected it.

1.3 Blame, responsibility and the notion of illness

There is a powerful discourse of personal responsibility and blame for depression, where it is seen as personal weakness, as something within the individual's control. This is potentially mitigated within the terms of what has been characterised here as a medical discourse of depression, which sees depression as an illness, as something which happens to people and which is out of their control, and which removes personal blame. In this sense a medical discourse is potentially liberating. But the notion of mental illness is stigmatising and devalues the individual person. Mental illness is seen not so much as a physical or biological problem for which the individual is not responsible, but as a problem of personal capability and irresponsibility.

1.4 Control and powerlessness

Depressive experiences are also conceptualised as experiences of powerlessness over oneself. Here the problem of depression is located in the individual. It is seen in terms of a loss of control, in a biological type discourse which sees the problem of depression in terms of individual pathology. Depression is also seen in terms of mental effectiveness, and as resolvable through personal power to change behaviour and influence the behaviour of others through positive thinking. But an alternative model of depression entails a recognition of relative powerlessness, of the importance of the socio-cultural context and of the individual's position within it.

1.5 Explanation and mystery

Throughout the interviews depression was identified as a clear problem, although understandings and explanations varied and were based on individual experiences. Individuals had also evolved different ways of dealing with depression based on their own experiences. Depression was conceptualised as an experience of self, which has meaning but is also a mystery which cannot be explained. Scientific and medical notions of depression as an illness are powerful in offering hope of explanation and resolution, but they do not appear to aid communication nor understanding.

1.6 The experience of an unacceptable self.

The experience of an unacceptable self can be understood as rooted in life history, as for example in Mary's reference to her experience as a child feeling rejected by her family, and that she was wrong (Part II, Part C, section 8, above). One possibility is that biographical experiences are incorporated into the self in the construction of the

“unacceptable self”. But depression also has meaning as an on-going experience, within the context of the individual's current life.

2. A review of methodology

The experience of interviewing and analysis of the data in this chapter suggested several key issues for consideration:

2.1 Interview design

Interviews with one participant were generally more successful, since they allowed an in-depth exploration of the participant's experiences and views. Interviews with two or more participants were problematic, since it was sometimes difficult to explore individuals' viewpoints in depth, and some individuals tended to dominate within the interview and others were less involved. Issues of confidentiality might be seen as a problem where more than one participant was involved in interviews. Practically, tape recordings were more difficult to transcribe where there was more than one participant since participants tended to overlap when speaking. However, group interviews provided a useful starting point for research, which could be followed up in one to one interviews, and also provided an opportunity for discussion which was less structured by the interviewer.

2.2. Variability of interview data.

There was considerable variability in the scope of interviews. Some interviews produced a diversity of themes, while others were based around a single theme. In some interviews individuals were exploring and developing their views on depression, in others individuals presented a more developed viewpoint. In some interviews individuals were reflective throughout the interview, in others opinions were given but individuals were less actively reflective in the course of the interview. For example, in the initial joint interview with John and Tim, John had quite clearly developed views on depression which he was less open to discuss or question, whereas Tim was more reflective about what depression was and what it meant to him, and expanded on this in his follow up interview.

Therefore, for the purpose of analysis, particular interviews and issues were focused upon. While seeking to also show the breadth of issues covered, some issues which emerged throughout interviews were investigated in more depth than others. Excerpts were selected with reference to particular interviews in order to build up a more in-depth analysis, by taking account of how issues were developed within individual interviews.

2.3 Experience and discourse

Throughout the process of data analysis in this study, the need to develop a methodology which looked at the content of individuals' experiences, and not only at how those experiences were discursively constructed within accounts, became apparent. This involved moving beyond the use of discourse analytic techniques, and looking at themes in experiences. (The notions of "themes" and "discourses" are more fully explored in Chapter Four, Part III, sections 1 and 2).

Based on the data analysis, depression was conceptualised as an experience of self. The analysis took account of the person rather than being limited to the text, seeing the person as active in constructing and reconstructing their experiences throughout the account. It is not simply a question of how experience is interpreted but of what has been experienced, and how individuals reflect upon and make sense of their experiences. (See Chapter Three, Part II, for further discussion of subjectivity and reflexivity).

2.4 Validation

In this study and in subsequent studies reported in the thesis (see Chapters Five, Six and Eight) a major concern was to acknowledge and not misrepresent the views of the person interviewed, and this became a consideration of validity. This concern reflected the felt responsibilities of the researcher to the participant, which was experienced as part of the interview relationship, as discussed earlier in this chapter (see Part I).

While the interview data in this study might have been differently interpreted by a reader who had not conducted the interview, part of the process of analysis and validation was constructing an analysis which was consistent with the actual experience of interviewing and within the context of the interview relationship. However, the analysis did not simply seek to reflect the viewpoint of the participant but to incorporate an acknowledgement of this into the analytic process, and to move beyond the participant's viewpoint, for example, in analysis of contradictions within accounts.

The analysis was not judged as an accurate reflection of a participant's views. This was one reason why it was not validated by taking it back to participants. Unlike standpoint research (Stanley and Wise, 1990), the validity of the analysis was not dependent on taking the standpoint of the participant. But the process of analysis did include acknowledging a participant's standpoint and using this in the analysis and deconstruction of the data. Analysis was subjective but not unrepresentative, but was interpretative rather than simply representative, seeking to move beyond the face value

of the text (Griffin, 1986). It sought to investigate the assumptions as well as the opinions of the research participant, looking at *how* participants made sense of their experiences as well as *what* sense they made of them.

It was also decided that it was inappropriate to take interpretations back to participants, for ethical reasons. To some extent any interview may be seen as an intervention, but to present participants with interpretations of their accounts might be personally challenging or disturbing, and I did not have sufficient expertise to support participants in this, since I was neither a counsellor nor a therapist. Such an approach would have been outside the remit of the research for this thesis.

Follow-up interviews were not designed to validate interpretations of the first interview. In follow-up interviews I briefly explained that I felt the participant had not been given a sufficient opportunity to express their views in the first interview, and briefly recapped issues which arose in the first interview, as a starting point for the follow-up interview. I did not present the participant with my interpretation of the first interview (in any case data analysis was in its early stages at that point).

3. Summary

Broad perspectives on understandings of depression have been identified in this initial study, as a basis for further research on the construction of understandings of depression within participants' accounts. The themes identified have emerged from the accounts of a general population, a group which is not usually studied, rather than a sample recruited because they were depressed. These themes are subsequently investigated in interviews with "experts" on depression: patients diagnosed as depressed (Study II, Chapter Five) and health professionals (Study III, Chapter Six). They were also investigated among a general population identified as vulnerable to depression: mothers of young children (Study IV, Chapter Eight).

Emergent issues are:

1. Depression may be understood as a meaningful experience of self. In particular, a depressed person may experience themselves as unacceptable and feel that they are misunderstood and rejected by others, within the framework of everyday social interactions.
2. The importance of the medical discourse, in recognising and validating the problem of depression in scientific terms, which are socially powerful and through which depression is identified as a "real" problem.
3. The need to develop a methodology which moves beyond the text, which is the focus of discourse analytic techniques, and which focuses on the person, and investigates what has been experienced and the meaning of experiences to the individual.

These issues, and related epistemological and methodological questions are further discussed in Chapters Three and Four.

CHAPTER THREE

DEVELOPING A THEORETICAL FRAMEWORK

INTRODUCTION

In Chapter One some of the mainstream approaches to depression were reviewed. In Chapter Two the use of a qualitative methodology in investigating understandings of depression was explored. In this chapter the epistemological basis of the research to be presented in later studies is discussed.

This chapter outlines the theoretical framework of the rest of the research presented in this thesis. It aims to shift the framework within which depression has been traditionally conceptualised in mainstream psychological and medical approaches from the positivist and objective conceptualisation which is commonly used (as discussed in Chapter One). The dualistic assumptions whereby depression is located in the individual in terms of pathology (e.g. Beck, 1967; 1979) or causation is located as external to the individual as in Brown and Harris' (1978) model of the social causes of depression, will be challenged.

The need to shift the framework for explaining depression from the positivist and objective framework used in the medical model was shown in the initial research project (discussed in Chapter Two). This explored the value of a qualitative methodology in investigating how concepts and experiences of depression were understood and accounted for among a general population. It was suggested that depression is a personally meaningful experience. A powerful medical discourse of depression can be used to validate and legitimate experiences of depression as real problems, but this did not provide a means of making sense of subjective experiences of depression.

The theoretical approach to depression developed in this thesis challenges the common assumption that depression is a clinical problem, which can be objectively identified and measured. It is argued that depression can be better understood as the experience of a person, as a subjective experience and as an experience of self. This is based on theoretical approaches which identify the importance of subjectivity within psychology and where the individual is seen as reflecting upon their experiences, as dynamically involved in these experiences, as acting in society, and through reflection incorporating social experiences into their construction of self. It draws from new approaches within psychology, from theoretical developments within psychology and sociology and from older traditions within psychology.

The issue of subjectivity has been avoided in mainstream approaches to depression (see Chapter One) which have followed a reductionist approach in an etiological model. This model looks at environmental causation and individual vulnerability, but does not investigate the complexity of the experience of depression, nor its meaning. In this chapter the theoretical underpinnings of an alternative approach are discussed, in which depression is seen as a subjective experience constructed through the process of social interaction, and understandings of depression are seen as socially constructed and incorporated into subjectivity.

The approach of this thesis is thus to examine the meaning of experiences of depression to individuals, and depression is approached as a subjective experience. It is suggested that meanings of experiences of depression are constructed through the social, personal and biographical experiences of a person's life. It will be argued that the production of meaning is both individual and collective. The construction of meaning is a dynamic process and the product of action, by collectivities of persons, which action happens within and is productive of the social structure. *Thus it is argued that depression cannot be approached as either an individual problem or a social problem, but must be approached as a dynamic process of interaction between individuals in their social world.*

Issues considered in this chapter, in discussing the epistemological basis of the research presented in the thesis include, in Part I, the development of new theoretical approaches in social psychology, which challenge traditional positivist approaches. This leads on, in Part II, to a consideration of the issues of subjectivity and reflexivity, and a theorisation of the self as actively involved in constructing the meaning of experience through processes of social interaction. Part III includes a consideration of how human experience is located within social structures, institutional and organisational constraints on that experience, and the social construction of its meaning. Issues in developing the analysis are considered in Part IV, including questions of realism and relativism in the interpretation of accounts, looking at the realistic nature of experience and the relativity of interpretations of experience. Finally, the research process itself is considered as an interpretative process, which seeks to deconstruct the meaning of subjective experience through an awareness of subjectivity and objectivity as processes within research.

PART I DEVELOPMENTS IN THE THEORETICAL BASIS OF SOCIAL PSYCHOLOGY

The research presented in this thesis is located within a tradition of social psychology which is non-positivist, non-dualist and philosophically and theoretically based, going back to the work of G.H.Mead (1934), but which has been neglected in mainstream social psychology, where an empiricist tradition has predominated (Harré and Secord, 1972).

1. The crisis in social psychology

The "natural science" tradition which has predominated in social psychology has been characterised as essentially empiricist and atheoretical. As Harré and Secord (1972) argue:

“The need for a comprehensive theoretical treatment of social psychology and for a reformed methodology we feel to be pressing, and to be evident from increasing dissatisfaction with the state of social psychology, even within citadels of the profession. The underlying reason for this state we believe to be a continued adherence to a positivist methodology, long after the theoretical justification for it, in naive behaviourism, has been repudiated. At present there is scarcely any coherent body of theory. In such a vacuum it is still possible to carry on empirical studies which make sense only if people are conceived of in the mechanical tradition as passive entities whose behaviour is the product of “impressed forces”, and whose own contribution to social action is the latent product of earlier impressed experience. A methodology of experiment survives in which the typical investigation is recommended to be the manipulation of “variables”, and the typical result a correlation in the manner of Boyle's law”. (Harré and Secord, 1972, p.1)

Harré and Secord argue that social psychology is in need of a revolution from within. It is empirically based but lacks any coherent theoretical basis. Persons are reduced to automatons. There is a crisis within the discipline, which is focused on its adherence to a positivistic methodology. The problem, it is suggested, is the failure to consider humans as persons rather than as the location of passive reactions. There is an inadequate theorisation of the person. As for example in the behaviourist tradition and Seligman's (1975) model of depression as "learned helplessness", where the individual's behaviour is understood in terms of their reactions to the environment without any consideration of how the individual experiences, understands or interprets the environment.

What is needed is not simply a revision of psychological methods, nor additional theory, but an alternative theorisation of human behaviour and a new approach to psychology (Harré, Clark and de Carlo, 1985).

2. Recent developments within social psychology

Taylor and Bogdan (1984) identified two major perspectives in social science research. Positivism adopts a natural science model of research, through data which is amenable to statistical analysis and "which seeks *facts* or *causes* of social phenomena apart from the subjective state of individuals" (Taylor and Bogdan, 1984, p.1). This is the tradition of mainstream social psychological research. The alternative approach is phenomenological and is rooted in philosophy and sociology, yielding descriptive data through qualitative methods, and also striving for understanding of people's actions on a personal level.

In the 1970's new theoretical and methodological approaches developed within what has been characterised as the "new paradigm social psychology". They drew on diverse theoretical and methodological traditions. They appear divorced from the distinct empirical tradition in psychology, although they can be rooted in the social sciences more broadly. For example, there is a strong tradition based on micro-sociology, from which ethnomethodology can be traced to conversation analysis to discourse analysis, and symbolic interactionism to interpretative and grounded theory approaches (Smith, 1993). These alternative approaches have had varied levels of impact within psychology. For example, co-operative enquiry is becoming established as an alternative tradition (e.g. Reason, 1988) rather than accepted as a mainstream approach, whereas discourse analysis (Potter and Wetherell, 1987) is now widely established as acceptable within social psychology

3. Contributions to developing a new psychological perspective

While the above alternative approaches may be located within a broad tradition of social science research it is less clear what is distinctly psychological in their theoretical stances. This leaves the problem identified above, the development of a new theory underlying social psychology, unresolved.

There is even some debate as to the importance of developing an explicitly psychological approach. Thus, while Henwood and Pidgeon have argued for the importance of qualitative methods for psychological theorising and for psychological research (Henwood and Pidgeon, 1992) others, in arguing for an interdisciplinary

approach, have suggested that there is no explicitly psychological stance nor any distinct role for psychology (Griffin and Phoenix, 1993).

It is argued here that a social psychological perspective implies a theorisation of the person involved in society, their experiences and the meaning of those experiences to them. It is indeed critically important that psychology does draw on other theoretical and methodological perspectives within the social sciences, and it is important to place psychology within the broader intellectual traditions of the social sciences (Smith, 1993). Other social science traditions offer social psychology alternative theoretical perspectives and offer the possibility for mainstream social psychology to draw itself out of its positivist and empiricist paradigm by the development of alternative theoretical positions. But it is critical that what is developed is a specifically psychological perspective if social psychology is not to become redundant. It is not enough to bring other traditions into psychology. What has to be done is to use them to develop explicitly psychological questions.

4. A new theoretical perspective in social psychology?

The problem of defining what psychology specifically has to offer has been avoided, through first drawing on the natural science paradigm and establishing the discipline around what are indeed mythical versions of the natural sciences and, more recently, through drawing on diverse traditions such as the micro-sociological (see Bryman, 1988), and the linguistic (Potter and Wetherell, 1987). It could be argued that, although social psychology is now drawing on a variety of social science traditions, the problem of developing an explicitly social psychological theoretical position remains unresolved. A cross-disciplinary approach can be adopted within psychology and used to critique mainstream psychology (see for example, Edwards and Potter (1992), for a critique of cognitive psychology from a position within discursive psychology). But this may only serve to critique traditional psychological approaches, rather than drawing on other approaches to revise or reconstruct the basis of psychological theorising.

4.1 Discourse analysis and the redundancy of the person

Discourse analysis (e.g. Potter and Wetherell, 1987; Edwards and Potter, 1992) has established a strong and recognised position within British social psychology (Smith, 1993).

Potter and Wetherell (1987) argue that an empiricist tradition has predominated within social psychology. They argue that non-experimental and theoretically driven approaches are still regarded with suspicion in psychology. Discourse analysts have

attempted to develop a theoretical basis for social psychology, and in doing so promote a cross-disciplinary perspective.

But new approaches and the emphasis on cross disciplinary perspectives may contain within them the potential redundancy of a social psychological perspective, if they do not constructively contribute to a redevelopment of explicitly psychological questions. For example, in the theoretical assumptions underlying the tradition of textual analysis in discourse analysis (Potter and Wetherell, 1987), as distinguished from the use of discourse analytic techniques (Henwood, 1993), the person is ignored. The individual is seen as the location of discourse and as constructed within discourse.

There is no room within this theoretical position for the person, who is actively reflecting upon and producing discourse, since in discourse analysis persons are constructed within the text, namely by and in the discourses speakers use (Smith, 1993).

The focus of analysis is discourse itself, taken as independent of persons:

“Participants' discourse or social texts are approached in their own right and not as a secondary route to things ‘beyond’ the text like attitudes, events or cognitive processes”. (Potter and Wetherell, 1987).

Discourse analysis can be seen as providing a strong argument against the reductionist assumptions of a cognitive approach which reduces the person to an inner core of cognitive processes. It argues that the evidence for human cognition is seen in discourse and that discourse should be the focus of analysis (Edwards and Potter, 1992).

Discourse analysis is in danger of undermining the validity of a psychological approach altogether by removing the person as a focus of study. Discourse is seen as the focus of study and the text as the end point of the analysis. The person is understood as positioned within the text. Discourse analysis can be seen as a form of social determinism, the person seen as a passive entity and as formed by and through discourse in a deterministic behavioural model. In the terms suggested by Harré and Secord (1972) above, the person is still seen as the product of "impressed forces" in the behaviourist tradition, this time the product of "impressed" linguistic forces.

The discourse analytic position of subsuming the person to the text cannot be maintained, since if language is seen as a process, it is also the product of persons using

it, who are actively involved in social action, and it is a product of interaction of individuals in society and within social structures.

5. An alternative theoretical tradition within the history of social psychology.

G.H. Mead's (1934) development of social behaviourism, as theory and philosophy underlying social psychology, addresses the complexity of a social psychological perspective which transcends dualism. It has been grossly neglected by social psychologists (Farr, 1990). But it provides the basis of a theoretically rooted and explicitly psychological approach.

Mead (1934) sees psychology as looking at neither the social nor the individual but at the complex dynamic of the person in social action:

"It [the social act] must be taken as a dynamic whole - as something going on - no part of which can be considered or understood by itself - a complex organic process... In social psychology we get at the process from the inside as well as the outside". (Mead, 1934, p.7)

It is suggested that the focus of social psychology is the social act and that this cannot be considered apart from the social process as a whole, of which the act is both product and part. Mead's (1934) theory of social behaviourism implies a reframing of the questions and theoretical framework of social psychology. Society and the individual are reconceptualised in terms of dynamic interactive processes, and the person is seen as incorporated into, acting on and themselves incorporating social processes.

In Mead's (1934) approach to social psychology the focus is on the individual involved in and reproducing social processes, rather than the individual conceptualised as separate from and divorced from the social environment as in a dualist model. This is further discussed later in this chapter (see Part II, section 6). Anthony Giddens' (1979) theory of structuration is also discussed, a theorisation of the individual's action in society, taking account of social processes on a micro-social level, where the individual is seen as part of and reproducing social structures in their actions.

Thus an alternative theorisation of social psychology is grounded in an analysis of actions as interactive social processes. This theoretical approach moves beyond the positivist paradigm since it is not polarised as either subjective or objective. It is not static but dynamic since it is concerned with process. It theorises persons as dynamic rather than passive, as contributing to social action rather than the passive and simple

products of social forces. It moves beyond the dualist model since the individual is seen as incorporating, reproducing and acting upon social processes.

Conceptualisations of the individual can be reworked and the self and the person reconceptualised in terms of a dynamic process of social interaction. Mead's (1934) approach to social psychology sees individual mind as formed in a dynamic process of social interaction, as emerging from society rather than performed. Meaning is constructed in an interactive process. Issues to be considered later in this chapter are subjectivity, meaning, reflexivity, and the concept of the social act.

6. Implications for the theorisation of depression

Depression can be conceptualised as an experience which has to be understood from the personal viewpoint of the person experiencing it as well as from the viewpoint of the observer. But it can also be understood in terms of processes of interaction of persons in society. This is in contrast to the mainstream approach which considers depression as a problem located in the individual or as having social causes which are external to the individual. Instead depression can be considered as an experience which is both personal and social, which can be understood in terms of individual's social experiences and as constructed through dynamic processes of social interaction.

This approach is best pursued using qualitative research methods which can look at how individuals construct subjectivity and meaning, and through in-depth analysis of accounts of experiences of depression. The construction of meaning is considered as a reflexive process drawing on collective and personal resources. This means looking at the content, meaning and interpretation of experiences. The qualitative and phenomenological analysis of accounts become the focus of a social psychological study of depression.

Questions which emerge from this approach are *what* is subjectively experienced as depression and *how* these experiences are subjectively interpreted as depression, and the use and meaning of the term "depression" as it is used in interpreting those experiences. It means looking not simply at the content of experience but also asking how experiences are interpreted. This includes an awareness of language as a social act, situated within and reproducing social structures and processes.

PART II THEORETICAL ISSUES AND RESEARCH QUESTIONS

1. Self, subjectivity and the experience of depression

Brown and Harris (1978) identified the self and identity as critical factors which should be investigated in order to move on from their own research findings (although they subsequently paid more attention to other aspects of the research), as discussed in Chapter One, Part II. Brown and Harris (1978) argued that the effect of provoking agents may be understood in terms of role identities but that "since little is known about the organisation of these identities we can only speculate" (Brown and Harris, 1978, p.237) and that:

"Consideration of the issue in terms of role identities relates it to social structure, which is where we think it belongs. For it is in the perception of oneself as successfully performing a role that inner and outer worlds meet, and internal and external resources come together". (Brown and Harris, 1978, p. 247)

Questions of role, identity and self-perception are related to social structure. But relations between the individual's inner and outer world are identified as a critical factor. Conceptualising the self as experienced in social interaction is a critical approach to the investigation of the individual's experiences of their social world.

Oatley and Bolton (1985), in a social cognitive model of depression, have conceptualised depression as a loss of self, experienced when a role which is critical in maintaining one's sense of self is lost. They argue that:

"If the role in question is the only one by which the person defines her- or himself, the collapse is experienced literally as a loss of a sense of self, and symptoms of depression emerge." (Oatley and Bolton, 1985, p.377)

Oatley and Bolton (1985) do not explain how the sense of self is formed, and although they draw on Mead's (1934) work theirs is not a dynamic model of self. They are interested in the maintenance and loss of self; through a specific life event, but not in the experience of self as an on-going process. They do not draw upon the full complexity of the individual's social experience but reduce the experience of self to the experience of a role (see Chapter One, Part II).

An investigation of subjective experiences of depression might explain the psychological impact of social factors, or how social causes of depression lead to the individual experience of depression. Explanations of the impact of social factors have

been limited within the dualist paradigm of the social science model, where the social causes of depression are seen as external to the individual (see Chapter One, Part II). The exploration of subjectivity in depression could extend the social science model, through looking at the meanings of social experiences to individuals and how social experiences are incorporated into the subjective experience of depression.

For example, Oatley and Bolton (1985) argue that the self is confirmed and maintained through expected behaviour of "role others" in role relationships. They argue that alternative roles will allow individuals to fulfil self-definition goals and thus can compensate for loss of another role. They, and similarly Thoits (1983), suggest that multiple role identities can be protective against depression.

But Oatley and Bolton (1985) fail to address how the self is experienced, or how meaning is subjectively constructed. They do not explain how individuals construct themselves through roles, nor do they explore the concept of role and the relation of role to experience of self within relationships. An exploration of subjectivity is needed to make sense of the relation between social factors, the individual's experiences of their social world and individual experiences of depression.

Within Oatley and Bolton's (1985) social cognitive model of depression the question of subjectivity is avoided and the self is reduced to a cognitive schema. They do not take account of the individual as actively and reflexively involved in the construction of meaning. Within the model, the relation between life events and depression is explained in terms of the individual's hypothesised cognitions, without any explanation of the *meaning* of experiences to individual, nor how they are *interpreted* and result in *particular* cognitive constructs.

2. Subjectivity

Subjectivity is understood within this thesis as the individual's interpretation of experience and the incorporation of social experience into their sense of self. However, the debate surrounding the notion of subjectivity is first discussed.

The debate surrounding subjectivity in social psychology is fairly recent (see for example, Henriques et al., 1984; Hollway, 1989). Subjectivity has until recently been neglected in mainstream social psychology within the terms of the predominant dualist model, where the individual is considered as separate and distinct from the social. Theorisation and analysis has been restricted to the acknowledgement that the individual is involved in a complex social process. Riley (1978) argued that:

"Attempts from within psychology to cope with the theoretical problems... have attempted to resolve themselves into the mere making of statements to the effect that 'a complex interaction' is at work, as if all the problems were solved thereby." (Riley, 1978, p.79)

Subjectivity represents a departure from the concept of the unitary individual within mainstream psychology. In looking at subjectivity the complexity of the person's experience becomes the focus of research.

2.1 The discursive construction of subjectivity.

From a post-structuralist perspective subjectivity refers to a position within discourse. Post-structuralism aims to deconstruct the ways in which meaning is constituted within language (Derrida, 1973), in order to uncover hidden layers of meaning by laying bare assumptions and moving beyond the taken for granted. Post-structuralism assumes that meaning is constituted in language and moves beyond the notion of the subject as agent in the construction of meaning (Weedon, 1987).

Subjectivity is a position in relation to discourses. Subjectivity is understood as that which is the subject of discourses. There is no notion of the subject as agent:

"We use subjectivity to refer to individuality and self-awareness - the condition of being the subject - but to understand in this usage that subjects are dynamic and multiple, always positioned in relation to discourses and practices and produced by these - the condition of being the subject". (Henriques et. al., 1984, p.3)

Thus subjectivity is the product of discourse. Subjectivity is reduced to a subject position in relation to discourses. There is no notion of the unitary individual since subjects, as products of the discursive process, are dynamic and multiple and subject positions are contradictory within discourses.

This discursive theorisation of subjectivity does not take adequate account of the *experience* of self and subjectivity. The understanding of subjectivity is taken no farther than the idea of positions within discourse. There is limited acknowledgement of the *person* as the producer and user of discourse. There is little attempt to formulate an understanding of the *experience* of the person as constructed within their account, since the focus is on the text and the identification of discursive positions within the text.

"In this view the subject is composed of, or exists as, a set of multiple and contradictory positionings or subjectivities... If this is the case, what accounts for the continuity of the subject and the subjective experience of identity?" (Henriques et. al., 1984, p.204)

A discursive approach to subject positions fails to offer a consistent account of the continuity of the person or of their identity. Instead, the notion of the person is replaced by that of discursive positions within the text. As the product of discourse the person has no continuity across time, contexts, experiences, or even within a text. There is no integrity of the person, there is little room within a post-structuralist position for the notion of the individual as an active agent, no concept of an active and reflective individual, and no concept of the self as an on-going experience.

Thus discourse analytic approaches within social psychology (for example, Potter and Wetherell, 1987; Parker, 1989, 1992) fail to provide an alternative theorisation of depression as the *subjective experience of a person*. Instead, depression is seen as a discursive construction within the text. This fails to take account of the reality and pain of depression for the person experiencing it.

While individuals may draw upon discourses in the giving of accounts, there is a reality to experiences which are more than and are not contained within discursive constructions within accounts. Experiences of depression have meaning as the on-going experience of a person and are interpreted as part of their on-going biography or career (Karp, 1994).

Discourse analytic *techniques*, however, may be useful in looking at how meanings are constructed discursively within accounts and in uncovering hidden meanings through the deconstruction of texts and accounts. Individuals' accounts of their experiences of depression are shaped by available discourses and, for example, it is difficult to talk about depression without using a medical discourse of depression as illness (Nicolson, 1988). Experiences are recognised and named within available discourses and, as in the recognition provided in a diagnosis of depression, this may change the person's interpretation of their experience and be incorporated into their sense of identity, for example in constructing their identity as depressed (Karp, 1994).

Discourse analysis does not provide an alternative to dualism in psychology. There is no attempt to transcend the division between the individual and the social. The person is reduced to a product of discourse. The concept of the person is not reduced to attitudes, cognitions, behaviours etc. as in mainstream approaches but to a linguistic

position. Rather than retheorising the person, the person is ignored. A consideration of the experience of depression as the experience of a person, using accounts as representations of experience rather than being confined to the text and the discursive constructions within it, lies outside a discourse analytic framework.

2.2 Subjectivity: the experience of a person

Alternatively, subjectivity can be understood as a personal notion of reality (Nicolson, 1988). The person is understood as actively reflecting upon their experiences.

Subjectivity is the dynamic experience of the self within processes of social interaction. This alternative understanding of subjectivity as process draws on the traditions of symbolic interactionism. Here subjectivity is conceptualised as an interpretation of reality, based on an understanding of the self and meaning as process:

“Symbolic interactionists assume that as thinking, acting, creative individuals, human beings respond to the action of others after interpreting these others intent and action. A symbolic interactionist perspective leads one to look at self and meaning as processes. Phenomenologists assume that subjective reality may take varied forms. This perspective fosters the researchers study of the multiple dimensions and realities of a person’s lived experience”. (Charmaz, 1990, p.1161).

This implies that subjectivity can be understood as the active interpretation of personal experience, and not simply the passive internalisation of experiences. It is a dynamic process of construction and reconstruction as the individual is involved in ever changing experiences. Since experience is changing and variable there are many realities and dimensions of subjectivity. The self is understood as multiple rather than unitary.

Subjectivity is on-going and biographical, personal and social. It is the construction and reconstruction of self through the individual’s on-going experience and biography (see Freeman, 1993). It involves the continuous reconstruction of self, through the reinterpretation of past experiences based on present experiences within the social process. This has been conceptualised by Giddens as "the reflexive moment of attention", involved in the constitution of an act from the continuous "*durée* of lived-through experience" (Giddens, 1979, p.55).

From this perspective, the experience of depression can be seen as an experience of self formed through social interaction. Subjectivity is an emergent personal reality which is shaped by social interaction and which incorporates versions of socially constructed knowledge (Berger and Luckman, 1966).

For example, women talking of their experiences after childbirth may avoid or adopt a socially constructed interpretation of "depression" as pathology, when they use or avoid the term in talking of their experiences (Nicolson 1988). They may find it inappropriate for experiences which they contextualise in terms of their daily lives (see Chapter Seven, Study IV for further discussion). The diagnosis of depression may also validate an individual's problems as real and be incorporated into individuals' identities as depressed psychiatric patients' (Karp, 1994; Lewis, 1995).

In other words, subjectivity is constructed as emergent from biographical and personal experiences and from a position in social structure. This leads to multiple and potentially contradictory constructions of experiences of depression. For example, patients diagnosed as suffering from depression explained their experiences in terms of life history and critical events such as unemployment (see Chapter Five), as well as drawing on a medical diagnosis of depression as pathology. Subjectivity is a dynamic personal construction of experience rather than a standpoint or position.

3. The reflexive self

Experiences of depression are not static but dynamic and constantly evolving. Mary, a university student discussed in Chapter Two, described her experiences as changing and dynamic, rather than as static. Her experiences of depression varied, and could be precipitated by underlying meanings constructed through different social contexts. This is in contrast to mainstream conceptualisations of depression as an objective state, as in psychiatric definitions (see Chapter One, Part I).

The notion of the reflexive self is essential to the concept of meaning, where meaning is understood as constructed through processes of social interaction. Meaning, subjectivity and the self are evolved through a process of reflexivity. The self is known through social action, and through active interpretation and reflection upon collective knowledge. Reflexivity is the consciousness of social and collective knowledge and of the self as object, constructed using collective resources.

The self is conceptualised in terms of the ability of humans to see themselves as an object in their environment. It emerges as a person takes part in roles with others,

internalises others' attitudes towards them and assesses these attitudes and themselves against these attitudes (Turner, 82).

The self is a behavioural concept since the self is evolved through acts and actions with others. Mead's (1934) concept of mind is essentially behavioural, not an entity but a process of behavioural adaptation to the environment. Mead's behaviourism as an approach to mind has often been neglected (Farr, 1994), including by symbolic interactionists who built on his theory within the tradition of micro-sociology. But his argument that both mind and self are behavioural processes is important in stressing the evolution of mind and self as social actions.

Mead (1934) conceptualised the self in terms of the "I" and the "me":

"The 'I' reacts to the self that arises through taking the attitude of others. Through taking these attitudes we have introduced the 'me' and we react to it as an 'I.'" (Mead, 1934, p.174)

The self is constructed through the internalisation of the attitudes of others, as an object, in the "me". The self operates on the levels of the "I" and the "me" and one is aware of oneself as an object, as a "me". The "I" reacts to the "me" as object.

This is not a simple process of internalisation. It is a reflexive process within the individual. The "me" is the product of self-awareness, it is the self as object. There is a distinction within the self between the "I" which acts and "me" as an object. The "me" is produced through internalised social acts, and is a collective product. The "I" operates as subject and is active.

Action, internalisation and reflection are vital in the evolution of the self. It is on the basis of reflection that the individual acts, and one is aware of oneself through reflection on past actions. The self is formed and expressed in a dynamic process of interaction with others and is constantly evolving through changing experience of the social world.

"The growth of the self arises out of partial disintegration, - the appearance of the different interests in the forum of reflection, the reconstruction of the social world, and the consequent appearance of the new self that answers to the new object". (Mead, 1913, p.379)

4. Meaning

The meaning of depression to an individual, I will argue, cannot be assessed objectively nor as separate from an individual's interpretation of their particular context. It is part of their experience of self. An objective measure of the meaning of life events, as used by Brown and Harris (1978) (see Chapter One, part II, section 2) leaves out any account of meaning as a personal construction which is incorporated into the individual's experience of self.

From a symbolic interactionist approach, meaning is understood as a process, as dynamic, formed through acts, and in constant transformation (Hewitt, 1984). It is an emergent reality which is shaped through social interaction (Berger and Luckman, 1966).

Although there has been a long tradition of concern with meaning in psychology, the concept of meaning has often been avoided or reduced to cognitive concepts, which are hypothesised in terms of the inner core of the individual. Meaning is reduced to cognitive structure rather than seen as a social process. From a dualist perspective, where the individual and society are seen as separate entities, the question of how meaning is formed through action is ignored.

4.1 Meaning as process

There is a neglected tradition within psychology, explaining meaning as formed through individual involvement in processes of social interaction. For example, Personal Construct Theory (Kelly, 1955) has largely been misinterpreted as implying a cognitive interpretation of the individual's world rather than as a process of action in the world (Nightingale, 1994). It emphasises meaning as process, formed through action in the social world, and transcends the dualism of cognitive theory where meaning is reduced to cognitive processes contained within the individual, instead seeing the individual forming constructs in an individual process of anticipation and of action within the world (Nightingale, 1994; Butt and Birr, 1994).

4.2 Meaning is personal and collective

Harré (1984) has argued that meaning is both personal and collective, and that:

"We should look outside ourselves to the conversations in which we engage for the primary location of such activities as reasoning, declining, making commitments and even feeling". (Harré, 1984, p. 128)

This suggests that meaning is not only located in the individual, in cognitive processes or cognitive structures, but also in the process of social communication. Meaning is constructed from social interaction as both a personal and collective product. Harré (1984) suggests that meaning is constructed discursively, based on public-collective conventions.

"There are public-collective conventions in terms of which we live our individual-private psychological lives. There is an array of persons and there is the discourse in which they are engaged. That discourse is subject to certain sorts of rhetorical conventions. It is these that determine for us what we appropriate from the public collective world and from which we make our own individual and private psychology." (Harré, 1984, p.135)

4.3 The structure of meaning

Giddens (1979) has conceptualised the structure of meaning and moved beyond Harré's emphasis on collectivity to look at how personal knowledge is structured. He identifies three elements, the unconscious (repressed knowledge), discursive consciousness (expressed in talk) and practical consciousness (the taken for granted drawn on in action). Giddens argues that while the giving of accounts refers to discursive capabilities of actors, which is the focus of Harré's viewpoint (Giddens, 1979), Harré's account ignores the role of practical consciousness, where tacit knowledge is used in conduct although the actor may not be able to formulate this knowledge in discourse.

Thus accounts given of behaviour and action may not incorporate practical consciousness, although this is active in the process of meaning in action, and there may be a mismatch between the rationalisation of action in everyday discourse and actors' stocks of knowledge. Thus meaning cannot be seen as incorporated within accounts which can be taken at face value but must also be seen as related to a stock of knowledge which is not necessarily directly evident within the account.

4.4 Meaning, discourse and accounts.

Meaning is therefore characterised as a process, as formed through action, and as not confined to discourse. While conscious knowledge may be seen in discourse, meaning and interpretation draw on unconscious knowledge and tacit practical knowledge. Meaning is not the product of discourse but discourse may be seen as the product of persons engaged in action and formulating meaning from a basis of discursive, practical and unconscious knowledge. Discourse does not incorporate meaning but merely demonstrates one form of consciousness, discursive consciousness.

Accounts can be seen not as incorporating meaning within discourse, but as the product of persons engaged in action and in the formulation of meaning, while drawing on this and other stocks of knowledge (the unconscious and practical consciousness). Meaning is not straightforwardly nor simply constructed in accounts. Accounts may be used as a resource in the interpretation of meaning and can be explored through the interpretative analysis of the text but meaning is not contained within or limited to the text. It is *partly* constructed within accounts as discursive actions.

Through the deconstruction of accounts hidden forms of knowledge may be uncovered (Henwood and Pidgeon, 1994). For example, unconscious or hidden knowledge may be indicated by the use of contradictory discourses. This may indicate meanings which lie beyond the discursive or conscious knowledge of the person giving the account. For example, an individual may describe experiences which can be identified as depressing experiences and refer to low mood and feelings of hopelessness, but avoid using the term "depression", and conscious knowledge of depression (Nicolson, 1988).

Subjectivity and conscious knowledge are limited by and shaped within available social discourses, which have multiple and potentially contradictory meanings. Individuals may use these in different ways, across time, contexts and experiences. For example, the use of the term depression as a self-description, as in "I'm feeling depressed today", can have a different meaning to the use of the term of depression as a description of a clinical state, illness or a medical condition. The use of the word "depression" has multiple meanings which may or may not be distinct. It both refers to an everyday experience of feeling down and has connotations of a clinical state.

For example, it is difficult to use the term "depression" without implying a clinical state, but at the same time individuals who have experiences of severe depression may find the term problematic because it is used to talk about everyday experiences, and does not convey what they perceive as the difference of their experiences. Participants explained that other people have no idea of the difficulties of their experiences of depression, understanding the term depression within a framework of everyday experiences of feeling blue, and yet they themselves also avoided use of the term depression since they understood it as a clinical and as a pathologising term. Examples of this were given in Chapter Two, (Part II, Parts A and B) from interviews with Ann and Mary, who suffered from what they described as severe depression, and further examples will be given based on psychiatric out-patients' descriptions of depression in Chapter Five.

5. Power

5.1 Power and subjectivity

Symbolic interactionism has been based on developments of Mead's work. Mead considered the individual's social world in terms of familial figures and the "generalised other". Symbolic interactionism has been limited to micro-sociology and concerned with the ways in which meaning is negotiated within small scale interactions (Giddens, 1979).

Mead himself did not elaborate any view of a differentiated society. Giddens (1979) argues that this has led to ignoring the operation of larger social and structural forces and their effects on individuals, within a symbolic interactionist perspective. Functionalism has taken over this aspect of sociology, but has given priority "to the object over the subject, or, in some sense, to structure over action" (Giddens, 1979, p. 50). Thus there is no account of how the construction of subjective meaning involves wider social structural issues, including issues of power within society.

Development of a Meadian perspective to take account of social and structural issues also offers a way of addressing power relations as they are incorporated into mind and self through the process of social interaction. The psychological implications of symbolic interactionism for the processes of self and for subjectivity have not been fully explored within psychology, which has largely ignored Mead's work, with some exceptions (for example: Ashworth, 1979; Nicolson, 1988). An analysis of subjectivity could expand the symbolic interactionist perspective in asking: how are social power relations, including gender power relations, experienced by individuals in their immediate relationships and incorporated into subjectivity? An expanded symbolic interactionist perspective enables an examination of how power relations are experienced by individuals, are embodied in their relationships and are internalised.

Mead considered the social in terms of a unified society, based around the concept of the "generalised other", which symbolised social values and which is internalised by the individual. Mead's major concern is with the emergence of the social self, (Giddens 1979) which Mead saw as a resolution between the individual and society.

Mead, in the concept of the "generalised other", implicitly assumes consensuality, through taking the place of the other. However, this is impossible once the operation of power relations is considered (Parker, 1989). Parker (1989), in his version of discourse analysis, draws on Foucault's (1973) work on the role of powerful discourses in the social construction of knowledge. This has implications for explaining individuals' interpretations of experience, as the product of socially produced discourses. The self is

a complex process, and differentiated aspects of society may be reflected in different discourses and in the evolution of multiple and contradictory meanings. As society is differentiated, so the self is multiple and contradictory rather than unitary or harmonious, reflecting the individual's experience of society which is also multiple, contradictory and ever-changing.

Thus the concept of the unitary society could be replaced by an analysis of society as multiple and diverse rather than unitary. The "generalised other" could be reinterpreted as representing not a resolution of experiences into a single, symbolic, social other, but the domination of particular social values reflecting power relations, overlying contradiction and conflict, rather than being symbolic of social values and of a process of social resolution.

5.2. Power and the experience of depression

Analysis of the incorporation of power relations into subjectivity may contribute to understanding how individuals come to experience themselves as depressed, relating this experience to social, structural and cultural processes. Mainstream psychological literature has suggested that depression can be conceptualised as powerlessness, loss of control and helplessness (see Chapter One, Part II, section 6). Gilbert (1992) has conceptualised depression as an experience of powerlessness, using an evolutionary biopsychosocial perspective. Learned Helplessness theory (Seligman, 1975) has paralleled depression to experiences of helplessness as individuals feel unable to control their environment. Attribution theory (Abramson et al., 1978) has been used to suggest that depression occurs when individuals make stable, global and internal attributions and experience themselves as unable to control their environment. This is compatible with personal experiences of powerlessness. But the question then is how power relations become incorporated into the individual's sense of self, taking account of macro-social relations as well as micro-social relations in intimate relationships.

The theoretical approach of symbolic interactionism, discussed above, where dominant values are incorporated into and shape experience and knowledge of self through intimate relationships, is implicit in Jack's (1991) analysis of women's experiences of depression in intimate relationships. Jack conducted a qualitative study which took a phenomenological, descriptive approach to depression, as the subjective experience of the depressed woman.

Jack (1991) understands women's experiences of depression as an experience of powerlessness, in relationships where cultural imbalances of gender power relations are experienced as a loss of self. Based on Gilligan's (1982) explication of women's sense

of self as relational rather than autonomous, and identifying the causes of depression as interpersonal, Jack (1991) inquires into the nature of women's relationships. The types of connection between men and women, experienced in intimate relationships, are of female compliance. She claims that:

"Depression is both individual and social; it combines the personal and the political. The relational perspective asserts that the self is social. Mind and self come into being through communication with others" (Jack, 1991, p.205)

Jack (1991) develops a Meadian perspective, taking account of power in social processes, and theorising how structural gender power relations are incorporated into the self through experiences of relationships at a micro social level. Thus she incorporates macro-sociological and micro-sociological levels into her analysis of subjectivity and the social experience of self.

Developing Mead's (1934) concept of the "generalised other", as a "system of common or social meanings", Jack (1991) argues that this explains how personal conduct is judged in moral terms which reflect dominant social values. This presents real problems for women, since moral values reflect dominant social patriarchal values and women feel that they are judged critically if they attempt to contradict these values or assert themselves:

"Only by taking the position of the generalised other can one understand or evaluate personal conduct in social - that is, moral - terms.

The problem for women enters precisely here. Taking the perspective of the generalised other divides a woman's experiences in two along lines specific to her gender. One part of the psychic whole identifies with patriarchal values and looks on herself from that internalised male gaze. This is part of what I have called the Over-Eye, which critically regards the woman's feminine, authentic self as an object and discounts its values and worth. The generalised other, representing dominant community values, stands over her with the threat of censure if she dares to challenge what her partner, the church, the institution or the patriarchy thinks is "right"... Because the collective "other" has the power to enforce its dominant vision, a woman finds it difficult to defy the authority and judgements of the Over-Eye and easily slips into seeing herself from its perspective. The

internalised male gaze, like a cataract over clear vision, occludes a woman's ability to see for herself and silences her willingness to speak from her own perspective.

Examples of silencing the self run through depressed women's narratives, most often in relationship to a male partner. A man can come to embody collective social judgements to a woman, either because he manifests them in his behaviour or demands or because she projects them on to him". (Jack, 1991, p.133)

Jack (1991) suggests here that the Meadian "generalised other" can be understood as embodying dominant male values, which appear as the social consensus, but within which women's experiences are devalued.

Jack (1991) argues that male values are internalised by women in three ways and at three different levels. First, at the individual level, they are internalised as a critical inner voice and the woman devalues female experiences which are not incorporated into male values. Second, at the community level patriarchal values are incorporated into moral constructions of what is good or appropriate behaviour for a woman, she conforms to this male-based view and is morally restricted within the terms of conventional patterns of behaviour and experience. Thirdly, at an interpersonal level relationships are shaped in terms of gender power relations.

As will be further discussed (Study IV, Chapter Eight), in interviews on their experiences as depression women who are mothers appear to judge their own experiences as mothers against social constructions of what a good mother is, which do not accord with the reality of female experience. At an interpersonal level, they were judged by male partners in terms of their identities as wives and mothers, which carried with them the need to live up to social ideological constructions of appropriate female behaviour. At a personal level, they were often unable to value their own experiences, or felt that they lacked recognition for the problems they were facing. They described their daily lives as isolated and themselves as the only source of validation of their own experience which was inadequate.

The complexity of social experience is presented in Jack's (1991) account in terms of gender. Potentially this can be extended to look at how gender constructions of appropriate behaviour present problems for men, whose moral identity is also structured in conventional social terms. By suggesting that the self is a gendered social construction it adds to Oatley and Bolton's (1985) social cognitive theory of depression as loss of self occurring when a role relationship, which is primary to a person's sense

of self, is lost (discussed in Chapter One). It is not simply that a role significant in the experience of self is lost, but that this role is vital in the social construction of an acceptable gender identity. Thus unemployment might represent a real loss of self, (Oatley and Bolton, 1985) if employment is essential to a successful and acceptable adult male gender identity, structured at many levels in the community and in interpersonal relationships. (The importance of loss experienced through unemployment within community and interpersonal relationships is discussed further in Chapter Five, Study II looking at patients' accounts of depression).

Consideration of the "internalised male gaze", in Jack's (1991) terms, suggests that women directly internalise male values. But Mead's (1934) theoretical approach, and in particular the notion of reflexivity, suggest that this is a more complex process, that women actively reflect upon dominant, male values, and to some extent negotiate them and reconceptualise them into terms more acceptable to themselves. Jack (1991) argues that women in depression lose their sense of self, and that this is a social problem in societies where female experience is devalued and not incorporated in dominant social values. However, women may also reflect upon and may themselves be aware of the discrepancy between their needs and their relationships and wider social values, and actively negotiate this discrepancy. This may also be true for men, in different ways.

An awareness of structural issues is needed to explain why women who may be aware of such discrepancies still experience themselves as powerless to effect change. Jack presents a personalised version of women's experiences, but one which does not suggest to what extent they experience or see their problems as structural, in terms of economic and financial constraints and restricted employment opportunities, nor how structural constraints themselves shape relationships for men and women. At an individual level, women may be aware of the power of male values and, rather than internalising them, reject those values but be structurally restricted in their opportunities to effect change. For some women this awareness and negotiation of structural problems and frustration and loss of freedom to act, rather than loss of voice or of self, may be part of the experience of depression.

The issue is not simply one of individual and personal experience but also one of wider social structural constraints which shape personal experiences. Women may actively reflect upon and reconceptualise social, structural constraints, in terms which make them more acceptable at a personal level but which may mean that knowledge of structural problems is repressed. Structural problems may be reformulated in terms of personal choices or decisions, which apparently empower the woman while avoiding recognising real structural constraints on her actions, and which in reality do not

increase her freedom of action. Currie (1988), in a study of how women make reproductive decisions, found that women personalise structural constraints, for example on child care and career breaks, reconceptualising them on a personal level in terms of "the right time" for the woman to have a child. Currie (1988) argues that the researcher needs to be aware of wider structural issues and use this awareness in the interpretation of data and, rather than taking a purely inductive approach, move beyond the standpoint of the woman herself, through looking at wider social and structural issues which have shaped the woman's experience. This may also be true for men, who may also interpret structural and social issues at a personal level, for example in experiences of unemployment (see Study II, Chapter Five).

Analysis of power issues in depression involves a wider awareness of power and of how power is structured in society, which moves beyond the question of whether individuals see themselves as powerless to looking at how issues of power are actively negotiated by individuals within the terms of their everyday lives. Power is a complex issue which operates at many levels, and women may experience themselves as powerful, for example in the domestic sphere (Condor, 1986), at the same time as they have little power in society as a whole. This may also be important in order in explaining why women do live within the constraints of their lives even when there is the possibility of change. A symbolic interactionist perspective may be helpful in explaining how power is symbolised at many different levels.

Conversely, an analysis of structural power relations is by itself insufficient in explaining women's experiences of depression. It simply locates the cause of individual problems in society. It does not explain how structural power relations are incorporated into individuals' experiences and the processes of self and subjectivity, which may be identified as the problems for social psychology. A feminist perspective, which sees depression simply as the product of social structure, as in gender power relations, does not explain how individual women negotiate and construct their subjectivity within such a structure. Nor does it offer a means of addressing individual problems in a constructive way, without the immediate prospect of social structural change (Ussher, 1991).

These issues are further explored, in relation to women's experiences of depression in motherhood, in Chapters Eight and Nine.

6. Structural issues

6.1 Structuration

Anthony Giddens' (1979) theory of structuration sees the individual as active in the social process and as indivisible from it. The duality of object and subject is transcended. The individual is active in shaping and is shaped by social processes. The theory of structuration reconceptualises the notions of social structure and the individual in terms of action of the person as within, incorporating and reinforcing social process. It takes account of social structure and incorporates the operation of macro sociological factors into the conceptualisation of self and subjectivity as social processes. Rejection of dualism underlies the theory:

"The concept of structuration involves that of the duality of structure which relates to the fundamentally recursive character of social life, and expresses the mutual dependence of structure and agency".
(Giddens, 1979, p.69)

Individual action can be seen as both reproducing the social process and constituting the social process. Structure and agency are not separate notions, but are reconceptualised in terms of a dynamic, recursive *process* of structuration.

Given the recursive nature of action, the individual cannot be considered as independent of the social as in the dualistic model. The theory of structuration offers a way of reconceptualising the links between individual and social worlds, overcoming the dualism of the individual and the social. The individual cannot be seen in objective terms. Nor can social structures be understood as existing independent of human agency.

Structuration presupposes a process of mutual action in interaction, which is consistent with a Meadian approach. Individual action can be seen as arising from other than individual cognitive causes (Nightingale, 1994). The person is not simply the product of the social as in the discourse analytic approach, where the self is seen as discursively produced, in a social determinist model. Personal construction of self can be seen as part of the social fabric of our lives at the same time as we perceive ourselves to be unique (Nightingale, 1994). For example, organisational structural processes can be seen as running through subjective experiences of professional work, in medically treating depressed patients, and subjective experiences of treatment as a patient. The subjective incorporates and formulates in action common social and organisational processes.

6.2 Social processes, organisations and institutional practices: Depression as constructed within the medical process

Organisational and institutional processes run through individual experience. Experience is both unique and common. Society is structured through organisations and institutions and these are formed through individual action, which takes place within and forms organisations and institutions. Organisational process both shapes individual action and is shaped through it, and it embodies and reflects wider social and cultural values.

Foucault (1978) argued that knowledge can be understood as circulating in social practices, and as reflecting the power structures of society. Knowledge is structured through social processes. Scientific knowledge is not considered as "objective truth" but as the product of powerful scientific institutions, and as a version of knowledge which is privileged through institutional power.

The employment of a discourse can be seen as reproducing power relations (Parker, 1992). The discourses which are powerful in society, which individuals internalise and which they use in interpreting and constructing accounts of their experiences, can thus be seen as the product of social power relations.

However, institutions do exist independent of discourses, though discourses may be the product of and reflect institutional power. Power may be transmitted through and reflected through discourse, but discourse must also be considered as the product of human action and experience within institutions and not as autonomously shaping that experience.

The concept of depression has meaning with reference to the medical system, the distribution of power and the allocation of power to treat patients (Gilbert, 1992). An awareness of the organisational structure of health care and the power of medicine and science within modern western society can be used to explain ways in which depression has been understood. It may explain the gap between medical discourses of depression as individual pathology, and patients' own subjective accounts of their experiences of depression. For example, women may avoid describing experiences using the powerful but potentially pathological term "depression", when they themselves understand them as structured within their roles and daily lives (Nicolson, 1988).

Patients may experience depression outside the medical system and in the community. Their experiences in the community and the meaning of those experiences may not be taken account of and incorporated into discourses surrounding concepts of depression

as a clinical problem, which are shaped within medical institutions. Clinicians' understandings are structured through their training in medical and psychological institutions and are likely to incorporate scientific discourses, through which depression is constructed as a pathological problem and which are fail to take account of depression as an experience of everyday life. This failing can be explained in terms of the social processes, organisations and organisational practices through which depression is identified and treated as a medical problem. For example, in Chapter Two, Study I, David, a medical student, spoke of the discrepancy between his understanding of his sister's experiences of depression, given his personal knowledge of her, and her doctors' apparent level of understanding of depression as a clinical problem in consultations. (These issues are investigated in Study II, Chapter Five and Study III, Chapter Six).

Experience of medical processes and the power of medical organisations may be reflected in accounts of subjective experiences of depression. As patients, depressed persons may incorporate medical discourses within their accounts of their experiences and come to understand those experiences as medical problems. For example, in Chapter Two, Study I, Ann, who had had extensive treatment for depression, understood it as a medical problem. In addition, Gilbert (1992) has pointed out that treatment by drugs may "send implicit messages to the miserable that their affective experience is illness and that drugs provide solutions to problems" (Gilbert, 1992, p480).

The organisational processes through which patients become assigned to G.P.'s, psychiatrists, clinical psychologists and other health professionals may also define what the problem of depression is, in terms of the operation and practices of the organisation and reflecting the values of that organisation. Thus definitions of depression as a medical problem may be based on organisational practice and can be understood in terms of organisational processes (see Study II, Chapter Five and Study III, Chapter Six).

PART III THEORETICAL ISSUES IN DEVELOPING AN ANALYTICAL METHOD

1. Variability and commonality in the construction of depression

1.1 Variability within and between individual experiences

An experience may be assessed *only* in terms of its common features as in the positivist approach, which objectively identifies features and which ignores individual meaning and variability. This has been demonstrated in the psychiatric approach to depression, based on the medical model and the identification of common symptoms in defining syndromes of depression (see Chapter One, Part 1).

But it is also necessary to investigate individual meaning in order to understand the implications and significance of objectively identified commonalities in state. Depression is meaningful at a subjective level:

"The way a person constructs and imputes meaning for a change in state will have an effect on the final expression of such a change... as well as on how an individual may set about coping with such changes." (Gilbert, 1992, p.22)

1.2 Common experience and abnormality

If an alternative to the account of depression as a problem contained within the individual is to be constructed, it is important to identify the commonality of experiences of depression, recognising that what may be experienced as individualised is a common and social phenomenon. Depression is common but experienced as individualised. Brown and Harris' (1978), in their work on the social causation of depression, identify depression as a common experience explicable in terms of everyday life in the community and caused by social factors (see Chapter One, Part II, section 1). Experience which may be seen as abnormal at an individual level can be explained at a social level and its definition as abnormal questioned.

"In some circumstances we believe it is as normal to develop depression as it is to develop a blister when a hand has been burnt by a hot stove, though it is unusual to see a burnt hand in a random selection of hands. We are only willing to see clinical depression in general as abnormal in this sense of unusual". (Brown and Harris 1978, p.45)

The categorisation of experience as abnormal often depends on whether it is addressed at a social or individual level. Often abnormality is assumed within a medical discourse:

at the individual level the unusual may be assumed to be pathological, without any real knowledge of what constitutes abnormality or what is normal.

Assumptions about the commonality of experience are incorporated into individuals' interpretations of their own experience.

A focus on both the commonality and variability of experience is needed in exploring the notion of depression as a common experience with individualised meanings, as an experience whose meanings draw on common social values and discourses, as a common but not a shared experience.

2. The interpretation of accounts of experience

2.1. The notion of the unitary individual.

Gergen (1989) has suggested that self-knowledge is socially constructed, through social discourses. The self as a unity is a social construction.

Shotter (1989) argues that the notion of the unitary individual and the notion of objective knowledge accessible to the individual is inadequate. The focus of research should be social processes going on between people, rather than an inner subjectivity contained in the individual. He argues that the notion of a unitary individual containing an inner self is itself a social construction. The self, as it is constructed within Western social and psychological discourses, assumes the model of the unified and self-contained individual. It is this assumption which psychology needs to explain, since this would explain the terms in which individuals interpret their own experience:

"Rather than attempting to account for ourselves and our world in terms of how we at present experience them, I shall be much more concerned to account for why, seemingly, we experience them as we do, for why at this moment in history we experience ourselves - or at least for why we account for our experience of ourselves - in such an individualistic way: as if we all existed from birth as separate, isolated individuals already containing 'minds' or 'mentalities' wholly within ourselves." (Shotter, 1989, pp.135-136)

2.2. The social construction of depression as an individualised experience

Thus the experience of depression as an individualised experience may be related to social constructions of the individual as unified and self-contained. Individuals' accounts can show how the individual is constructed within social interaction, drawing on social and cultural values.

Thus the characterisation of oneself as "depressed" draws on social knowledge about depression, and is based on the characterisation of depression as located in the individual and of the self as a unity in social discourses. Self-knowledge is both collective and reflective. It is neither individual nor social. Meaning and knowledge, including self-knowledge, are constructed through interactive processes.

2.3. Knowledge as an institutional production

Knowledge can be understood as constructed within an institutional framework and as the result of organisational processes. Depression as a psychiatric diagnosis can be seen to be constructed within and according to the professional, institutional and social needs of the psychiatric profession (see Chapter One, Part I): for example, DSM III R has been characterised as a social document, which exists to serve professional purposes, rather than as a scientific document (Widiger and Trull, 1991). The identification of depression as a medical syndrome can itself be seen as the product of social processes and values, and as rendered meaningful only within a consideration of knowledge as social process.

Formal medical knowledge about depression partially shapes and reflects the experiences and practices of clinicians, but their experiences are also more complex. The meaning of the psychiatric diagnosis is structured by clinicians in practice at an individual level, through their experiences and reflections on those experiences. (This is further discussed in Chapter Six, Study III). But psychiatric diagnostic procedures provide a justification of psychiatric practice and a defence and delineation of such practice in the wider social arena, in terms of the legal and ethical responsibilities of psychiatrists.

Within psychology, women's experiences of depression have been explained as psychopathology and mainstream psychology has failed to take account of the meaning of those experiences for women themselves. This is seen, for example, in the identification of 'dependency', as a factor in depression which is evidence of defective (female) psychology (Birtchnell, 1988), rather than as the result of and a way of dealing with female roles and women's experiences in relationships, considering the social, economic and structural context of women's lives (Cadbury, 1991).

Work in the psychology of women and feminist analyses have drawn attention to the ways in which women's experience has been ignored, devalued and characterised as deficient in the production of science generally and in psychology. Women's experiences of depression have been explained through reference to a medical and

biological discourse which pathologises all women in terms of their reproductive biology (see Nicolson 1991, 1992, 1993a; Ussher 1989, 1991, 1992). The medical discourse has been used to pathologise women's experiences of depression as the product of dysfunctional female biology rather than explaining depression as a social experience (Ussher, 1991). For example, the concept of "post natal depression" has been used to pathologise women's experiences as biological dysfunction, rather than looking at what these experiences are (Nicolson, 1988). Problems are located within the individual, as a characteristic of female gender, in terms of individual psychological dysfunction. The construction of women's experiences of depression as mothers with reference to a clinical/ medical discourse will be discussed in Chapter Seven and Study IV, Chapter Eight.

The powerful medical profession and powerful medical institutions shape social practices in regard to depression, and reinforce the medicalisation of depression and the institutionalisation of depression as a medical problem. For example, medical treatment is cheaper and easier than social changes, whatever the identified causes of depression, and provides an easier and cheaper government policy (Gilbert, 1992).

PART IV THE RESEARCH PROCESS.

1 The interpretation of accounts of experience

1.1 Social and individual levels of analysis.

It cannot be assumed that because depression is experienced by individuals as an individualised experience, depression is a problem contained within the individual. What must be considered is the non-availability of alternative ways of accounting for experiences of depression.

This approach need not be seen as invoking the "relative nihilism" of many social constructionist accounts (Shotter, 1993, p.89), where the analysis is limited to looking at experiences as relative constructions rather than looking at experiences as real in themselves. Rather, it can be seen as adding another layer to the interpretative analysis of how individuals interpret their experiences. Individual experience can be understood as constructed from collective and social resources, while also maintaining an individual and personal meaning.

Awareness of collective knowledge resources and social discourses is essential to the interpretation of individual accounts and to the analysis of individual meanings as constructed within accounts. The power of public conventions has to be considered within the interpretation of accounts, as formative of the ways in which individuals interpret and account for their own experiences (Harré, 1984). For example, the medical discourse of depression as illness is powerful in shaping understandings of depression, especially among clinicians and patients (see Chapters Five and Six).

An awareness of collective and social issues is essential in interpreting individual experience. Individuals experience their social world. Individual interpretations of experiences are located within social processes and are not merely the product of those processes, since the individual in action both constructs meaning within social processes and contributes to social processes. For example, in looking at whether or not individuals are seen as depressed by others and experience themselves as depressed, it is essential to ask how the term depression is understood within the social structure in which the individual is involved. Within and through the medical system depression is defined as a medical problem, and for those involved in giving and receiving treatment that system defines their functions, roles and identities as patients and clinicians (see Chapters Five and Six).

1.2 A realist position on experience within relative accounts

The analysis of accounts in this thesis is based on the premise that there is an experience beyond the account, of which the account is only a partial representation. The account is one way open for the researcher to study that experience. Accounts are not merely anecdotal but can be used to show common themes in experience and the variability of subjective experiences. Although accounts are partial representations of experience, versions given in accounts contribute to understandings of real experiences. There is a reality of experience which lies beyond the relativity of variable accounts, of which each account is representational.

It is argued that the experience of depression is socially constructed in two ways: firstly, in terms of the version of experience presented in the account, which draws on socially constructed knowledge of depression, and secondly, as an experience which is part of and incorporates social process.

What is discursively formulated offers only a partial account of activity (Nightingale, 1994). But while accounts contain unique individual perspectives, and the quality of knowledge contained in them may be unique, this does not lead to a claim for epistemological relativism. That would be to confuse the content of knowledge as discursively constructed within an account with a claim that what *can* be known is relative (Nightingale, 1994). Thus it can be argued that individuals' experiences are real, while their accounts and the meaning of them to each individual may be relative and partial representations of that experience.

Depression can be approached through analysis of individual accounts of experience which, while they may be relative and variable accounts (and at a different time or in a different context the individual may give a different account), also refer to experience which was real for the individual. To argue for epistemological relativity and against the reality of the experience of self is of little use in applied settings (Butt and Birr, 1994). Nor is it of use when individuals themselves experience depression as real and their suffering is real. A relativist approach lays it open for the analyst to ignore the reality of the experience of depression for the individual.

Variability occurs both within and between accounts. But this does not detract from the notion of the reality of those accounts. The experience of the individual is real, social processes are real and institutional structures are real and are experienced by individuals as reality. Accounts may be partial representations of meaning, and always open to reconstruction.

One question is how social constructions and discourses are drawn upon by individuals in the construction of accounts and subjectivity. Shared social constructions of knowledge are incorporated within individual accounts, but the meaning of socially constructed knowledge within interpretations of individual experience may be variable. Thus common social practices and discourses may be embodied in variable and individual interpretations.

The theories of symbolic interactionism and of structuration offer the possibility of conceptualising subjective experience in terms of a dynamic duality of individual experience as being interactively both personal and social. Powerful social processes can be seen as reproduced by individuals at the same time as they construct their own unique version of them and participate in them. Accounts show both common themes and individual variability in interpretation of experience. Thus in accounts of depression individuals can be seen as both reproducing the dominant medical conceptualisation of depression within, and as constructing unique accounts of, their own subjectivity.

2. Reflexivity within the research process.

Individuals' accounts of experience are both personal and social, reflecting and constituting social processes. Accounts are subjective interpretations of experiences, constructed within a social framework. They have subjective and common features. They need not be taken at face value but the interpretations contained within accounts can themselves be interpreted and explained.

Burkitt (1991) argues that it is necessary to theorise the relation between the individual and the social worlds, but this is impossible given that relations are conceptualised in terms of the individual and society as distinct entities. In other words, for psychologists who have themselves internalised from their culture a dualistic discourse, which structures problems in terms of the individual and the social, and whose discourses actively structure the unified individual, and for participants in research who share this conceptualisation, is it possible to move beyond the confines of dualism?

However, as suggested by Gergen (1989) and Shotter (1989), above, it is possible to become aware of how experience is socially structured through analysis of social discourses used, and this awareness may be incorporated into the interpretative research process. This demands that psychological research becomes both a deconstructive and reflexive process (Henwood and Pidgeon, 1994). Rather than approaching accounts as either self-contained texts or at face value, the social position of both the participant and

the researcher is considered, and the researcher works to become aware of both participants' and her own position within the social process.

In the deconstructive analysis of accounts, layers of meaning are unpacked (deconstruction) through looking at the ways in which objects of knowledge are constructed, uncovering what is usually invisible within discourses (Henwood and Pidgeon, 1994). This involves acknowledgement of the reflexivity of both the researcher and researched within the research process. The researcher can become increasingly sensitised to issues of meaning within accounts through reflexive awareness of her own social positions and assumptions, an awareness which can be developed through the research process, in interviewing and analysis of interviews.

In this sense research is itself a reflexive and social process, involving an ongoing interaction between the researcher and the interview as a transcript and as an actual (remembered) experience. Participants' reflexivity within the interview is grounded within accounts through which participants reflexively attempt to make sense of and reconstruct their experiences. Interviews are dynamic and reflexive, and meaning is constructed and reconstructed in an on-going process throughout the research interview and process of data analysis.

A Meadian analysis challenges a number of dualisms (Burkitt, 1991): between self/ society, mind/ behaviour, structure/ agency. These can also be considered as issues within the research process. The theory of structuration also offers a challenge to traditional views of objectivity and subjectivity as polar positions within the research process, instead conceptualising them as processes within research. This draws on the concept of reflexivity suggested in Mead's (1934) analysis of the self, where the process of reflexivity is a dialectic between the "I" of action and the "me" of the self as object.

Taking account of reflexivity in the research process involves moving beyond an analysis which seeks to ground theory on the experiences of research participants as seen in their terms. So while feminist analysis has argued that knowledge must be generated from the perspective of all social groups (Harding, 1991), this does not preclude an interpretation which takes into account the socially situated standpoint from which participants generated their accounts (Henwood and Pidgeon, 1994). This opens the way to an interpretative process in which, while women's experiences are judged in their own terms, an analysis of the terms available to women in which to construct their experience enables the discovery of hidden elements as in deconstructionism, and of tacit or unconscious knowledge as in Giddens' (1979) notions of unconscious and

practical knowledge (see above. Part II, section 4.3). This approach to analysis enables an exploration of the subjectivity of the research participant.

An approach in which the researcher transcends the personal world of the research participant (Currie, 1988) allows the researcher to identify the impact of macro-social processes on the subjectivity of the participant within the account rendered, by taking account of the terms in which the participant's account is constructed or, in other words, interpreting the participant's interpretation. This is important to the notion of subjectivity since it may enable an investigation of how participants construct their subjectivity while taking account of "objective" structural factors. Currie (1988), in her investigation of women's reproductive decisions, shows women conceptualising structural and social issues as personal issues and devising strategies which represent individualised or personal solutions to structural processes. This enables a woman to explain her experiences in terms which are acceptable to herself, given her biographical and social position. Thus she may identify external structural constraints but see them as irrelevant to her own experience. (See also Dryden, 1989, for an analysis of how structural gender inequality is distanced from participants' accounts of their own heterosexual relationships).

An interpretative approach to experience must thus take account of the subjectivity of the researcher, and the researcher's relationship to cultural meaning systems, and of participants' understandings and their relationships to wider meaning systems (Henwood and Pidgeon, 1995), where cultural meaning systems are also considered as systems of power. (My experience of the research for this thesis is discussed in Chapter Ten, Part III, Part C). The research process can thus in itself be seen as a process which is both objective and subjective, in an approach which incorporates an awareness of subjectivity and objectivity as interrelated processes within research rather than as polar positions. This can be seen as representing a move towards an "objective subjectivity" (Henwood and Pidgeon, 1994).

As noted earlier, Henwood and Pidgeon (1994) have argued that Grounded Theory may be used as a resource for reflexive and deconstructive analysis. They have suggested that while theory is grounded in interview data, a constructionist version may be used, drawing on the work of Charmaz (1990). This explicitly clarifies the researcher's own perspective as a resource within the research process, and as an essential element in research, which the researcher builds on in constructing analysis. This is built into the analytical process, in a process of "flip-flop" between interpretation and data (Henwood and Pidgeon, 1992).

The researcher's relationship to the research data can be conceptualised as a reflexive relationship. The researcher subjectively reads and interprets data, then considers their own interpretation as object, and seeks to validate their own interpretation within the body of data. In deconstructing, and looking for hidden meanings within the account of the research participant, the researcher is objectifying the participant's process of interpretation at the same time as they are formulating their own subjective interpretation.

This is essential to research within social psychology taking the theoretical perspective outlined here, where subjectivity is seen as part and process of social structure. It is essential to acknowledge and incorporate within the research process the researcher's own position within the social process, and the dialectical process whereby research accounts are developed and validated through interpretation of and grounding in the research data.

3. Summary

In summary, Chapter Three started with a review of recent developments within social psychology, and of the need to construct a stronger theoretical basis within social psychology, and to move away from positivism. It was suggested that Mead's (1934) theory of social behaviourism provided a theoretical basis which could be developed in explaining experiences of depression. Recent developments in social psychology were reviewed, the concepts of subjectivity and reflexivity were discussed, and the issues of meaning, social structure and power were highlighted as neglected areas in social psychology. The implications of these issues for the research process as an interpretative process were then discussed.

The methodology subsequently developed in this thesis, informed by the epistemological issues discussed here, and the design of the research studies, are outlined in Chapter Four.

CHAPTER FOUR. **THEORY TO METHODOLOGY: THE DESIGN** **AND THE DEVELOPMENT OF** **METHODOLOGY**

INTRODUCTION

This chapter gives a broad outline of the design of the main studies of the thesis, together with a preliminary introduction to the process of research and the development of the methodology. This is designed as a guide and introduction to the studies to come. It should be noted here that the methodology has been developed throughout the studies presented in this thesis and that, while issues are highlighted here, the specific methodology used in each study is discussed fully in that study. More details are given about the mechanics of the methodology in Appendix B.

PART I DESIGN

AIMS

The aim of the research is to look at:

1. Subjective experiences of depression.
2. The meaning of the term depression, and the discourses surrounding it.

This is based on the epistemology discussed in Chapter Three. It is based on the principles of symbolic interactionism (Mead, 1934; Blumer, 1969): that all objects and events acquire meaning through human processes of sense making; that meanings are not inherent but are formed by humans in processes of social interaction; that all human experiences are exercises in sense making. This leads to an understanding of self and meaning as processes.

1. The subjective experience of depression

The focus of this research is on the experience of self in depression: looking at depression as a subjective experience, and one which has meaning as an experience of self constructed through social interaction (Oatley and Bolton, 1985; Jack, 1991; Karp, 1994).

The research aims to look at depression as the lived experience of a person, through the analysis of subjective accounts of depression. This involves approaching depression as a dynamic, variable and complex experience, following a phenomenological perspective on

the multiple dimensions and realities of subjective experience (Charmaz, 1990), and emphasising the dynamic and constantly evolving nature of subjective experience.

The aim is to identify commonalities and variabilities within and between individuals' accounts of experiences, in cross-sectional studies, looking at depression as the experience of an individual, and incorporating this into an analysis of common themes and variabilities in the construction and interpretation of that experience.

Since the study was cross-sectional but not longitudinal experience could not be traced as it changed over time, (compare for example Nicolson's (1988) longitudinal study of women's experiences of post-natal depression). Instead participants' accounts of subjective experiences were used to look at how current and past experiences are described and identified as depression, and at the meaning of those experiences. The development of accounts and the meaning of experience can be investigated as constructed by participants within their accounts. While it is acknowledged that different accounts might have been gathered at a different point in time, and to some extent this can be seen in the accounts themselves (for example, participants such as Penny, Study IV, Chapter Eight, who said that she had been depressed in the recent past and would have provided a different account then), the aim was to look at the complexity of experiences and the dynamic process of interpretation, rather than the development of experience over time.

2. "Depression"

The research aims to investigate the meaning of the term depression, following a social constructionist view that terms acquire meaning and a social reality is constructed through processes of social interaction (Berger and Luckmann, 1966).

This involves looking at how the meaning of the term depression is constructed. Following a symbolic interactionist perspective, meanings are seen to be formed in social interactions, and to be constructed and conveyed through the use of language (Charmaz, 1990), and shared social values are understood as learnt with language (Mead, 1934). Thus an analysis of language or discourses used in accounts of depression can enable a deconstruction of those accounts, uncovering hidden meanings and making the implicit explicit (Henwood and Pidgeon, 1994). It can enable an identification of the discourses or language available to individuals, through which to construct accounts of subjective experiences. The identification of contradictions and inconsistencies within accounts may be used to identify the limits of discourse or language, and the gap between subjective experiences and available social constructions of those experiences. For example, in looking at the role of powerful social discourses in the construction of depression, and in

particular clinical discourses in the construction of depression as an illness or pathology, it can be asked: how appropriate are these discourses for constructions of subjective experience? is subjective experience understood as pathological? if, how and when are these discourses used in subjective accounts of depression? and what other discourses are available for the construction of accounts of depression?

THE RESEARCH DESIGN

The research involved four studies. The exploratory study, Study I has been described in Chapter Two, and was a preliminary investigation of social discourses surrounding depression and of the use of a qualitative methodology in exploring understandings and experiences of depression.

The main research studies are structured around two issues emerging from Study I (Chapter Two), from the review of literature on depression (Chapter One), and from the epistemological underpinnings of the thesis (Chapter Three). These are, firstly, the significance of understandings of depression as an illness, and the construction of depression as pathology and, secondly, depression as an experience of self, and the construction of depression through experiences of gender, roles and identity. The research design is presented here in two parts.

Part A. To investigate the significance of explaining depression as an illness, and the construction of depression as pathology.

The significance of explaining depression as an illness and the construction of depression as pathology were clearly identified as issues in the review of the research literature, where depression has been approached as a clinical problem on the basis of symptomatology, (see Chapter One). This literature does not incorporate analysis of depression as a subjective experience. Such an approach is taken in Study II, below, and the construction of depression as a problem by practising health professionals is investigated in Study III, below.

Study II Patients' subjective experiences of depression (Chapter Five):

This interview study with patients diagnosed as depressed (N=9), and being treated for depression as general practice patients (N=3) or psychiatric out-patients (N=6), aimed to look at patients' subjective experiences of depression and whether they understood depression as a clinical problem.

Questions included: how far participants, who were patients diagnosed as depressed and receiving treatment for depression, understood their own experiences as pathology; how

far they used a medical discourse in interpreting and explaining subjective experiences as pathology; what alternative accounts they gave of their experiences and how compatible these are with clinical conceptualisations of depression as pathology.

Study III Health professionals' understandings of depression (Chapter Six):

This interview study with health professionals (N=26) involved in the treatment of depression, investigated the health professionals' concepts and experiences of depression. Health professionals were seen as influential in two ways: as those involved in helping persons suffering from depression, often the only available source of help, and as a powerful knowledge source on depression (directly for patients and more widely through the dissemination of medical and scientific knowledge in the media). The study aimed to investigate in more detail clinical notions of depression as pathology, through the accounts of practising clinicians.

Part B. Depression as an experience of self: gender, roles and identity

The aim in this section of the research was to examine the complexity of subjective experiences of depression, and in particular depression as an experience of self constructed through social interaction (Oatley and Bolton, 1985; Jack, 1991). This involved looking at lay experiences and notions of depression, using a population of women who were mothers, who were not selected on the basis of having been diagnosed as depressed (see Study IV below, and Chapter Eight).

The research involved looking at depression as an experience of self and subjectivity and at how notions and experiences of depression are constructed in and as part of everyday life, among women experiencing motherhood. This was a development of, and built upon, Studies I, II, and III, since the identification of experiences as depression involves the use of socially constructed notions of depression, including the notion of depression as pathology, and alternative constructions of depression, for example as feeling blue or low where depression is not necessarily understood as a pathological state. However, it was broader than previous studies detailed above since it involved looking at what was depressing about the women's experiences of motherhood, and how the construction of identity and the experience of self as a mother is incorporated into experiences of depression.

Study IV Experiences of depression among mothers (Chapter Eight)

Participants were women who were mothers (N=18), and vulnerable to depression.

The study aimed to investigate:

- a) Subjective experiences of depression among women who are mothers.
- b) What is depressing about their lives as mothers.
- c) The significance of gender in the construction of self and identity in women's experiences of motherhood, and whether and how this is incorporated into experiences of depression.

PART II THE RESEARCH PROCESS

The research and writing of this thesis has involved taking several approaches to analysis of the data, since the richness of the data is such that a single structure of analysis would not have done it justice. The analyses presented should be read as parallel analyses rather than as linear, although the structure of a thesis dictates that they are presented as linear.

The research developed as progressive approaches to analysis and emergent themes were linked and related, and this led to new insights in the interpretation of the data. Research was a recursive process, as each stage in the analysis could be used to restructure earlier analyses. It would have been possible to endlessly construct new approaches to the data and to view it in different ways, and this could lead to a linking of themes into a different conceptual approach, and a reinterpretation of earlier interpretative work and ideas. This was potentially an endless process and one difficulty has been to draw the process to conclusion in writing up this thesis.

It has been important to recognise that the writing of the thesis consists of writing an account of the research process, and that in this research the process is in itself meaningful, not simply the results and conclusions drawn from the research. Thus the research results presented here are not conclusive but represent particular approaches in the research process and particular developments and points reached in that process. There is no attempt to suggest that these are the only possible interpretations or modes of analysis possible with this data. Although the analysis presented is one which I believe is validated with reference to the data, and although it is not presented as a relativist analysis (see Chapter Three, Part IV, section 1.2), neither is it presented as an exhaustive, comprehensive or finally conclusive analysis.

The research process is essentially an interpretative and subjective process (see Chapter Three, Part IV, section 2). It could be argued that the only way in which the research could be fully presented would be to have video recorded the interviews so that the reader could have access to the full range of data to which I was exposed as a researcher, although even then they would not have had the experience of taking part in the interview. It is obviously difficult to convey to the reader the complexity of the interview and research processes, and the initial impact of the interviews, and what is provided here is a selected, edited and interpretative account of those interviews, which seeks to do justice to the meaning of the interviews. The role of the researcher is seen as to edit, select and interpret the information presented within the interviews, in what is essentially a subjective process which seeks to do justice to the viewpoints of participants.

This is a dynamic process where the researcher is necessarily deeply embedded in the research material. The research account presented should be read as taking account of this:

Firstly, in the process of transcribing some of the data is inevitably lost, since the reader is unaware of the facial expressions and tones of voice which accompanied the words and of which I have been aware in interpreting and selecting data for presentation. I have not attempted to convey this in the research account because the interviews were real and not dramatic exercises, and this would be inappropriate to the constraints of my ability and training as a social science researcher.

Secondly, I myself and my understanding and interpretation of the interviews was inevitably changed in the process of going through those interviews. Thus meanings of interviews changed through subsequent readings, and this was partly a reflection on my changed understanding and position as I went through the research process.

Thirdly, as a result of reading and rereading interviews, as readings became more informed and as links were made between and within interviews, the salience of the data changed. Thus the interview excerpts which are presented in this analysis are presented because I thought that they were important to the participant concerned, and/or because I considered that they were representative of similar comments made by other participants and provided the best example of a particular experience or interpretation of experience. To some extent this has to be taken on trust as the result of a long process of validation and verification through repeated readings of the research data, but the validity of these excerpts is hopefully demonstrated through the coherence of the interpretative analytic account presented.

PART III METHODOLOGY: ANALYSIS OF THE DATA

Here a broad outline of the methodological approach developed is given. The methodology developed for each study is explained in more detail in that study. More details about the mechanics of developing the methodology are given in Appendix B.

All interviews were taped and transcribed. Interviews were then read and reread, as the starting phase of analysis.

A methodology for data analysis has been developed throughout the studies in order to best answer the questions posed above, and is informed by a range of methodologies rather than following a single prescriptive methodology. The theoretical approach of the thesis is based on symbolic interactionism (Mead, 1934; Blumer, 1969) but no prescriptive methodology based on symbolic interactionism was available or appropriate. Thus methodology was developed throughout the studies in an evolutionary process. This drew particularly on discourse analytic techniques (Potter and Wetherell, 1987) and on Grounded Theory (Glaser and Strauss, 1967; Strauss and Corbin, 1990), as developed from a psychological perspective as a resource for reflexive research (Henwood and Pidgeon, 1992, 1994, 1995) and to incorporate a social constructionist version (Charmaz, 1990). Methodological development was also more broadly informed by awareness of developments in theoretical and methodological approaches in the social sciences (Taylor and Bogdan, 1984; Rowan and Reason, 1981) and developments in feminist research methods (Wilkinson, 1986; Stanley and Wise, 1983; Nicolson, 1988).

The methodological approaches used were developed throughout the individual studies, where more detail is given. A broad outline only is given here, in order to draw attention to some of the issues discussed later. It should also be noted that, although the studies were designed and commenced in the order presented in the thesis, data was re-analysed in recursive process and later developments in methodology were incorporated into earlier studies as seemed appropriate to address the questions posed. Thus the development of the methodology was in parallel as well as in sequence. For example, the notion of themes is prevalent throughout the studies, and "thematic analysis" was developed as a methodology in different ways throughout individual studies.

The accounts contained a number of themes which it was felt were of central importance to the psychology of depression. The emphasis in the development of the analysis and the presentation of this research has been to look at what experiences are presented in accounts and at the way experiences are understood and structured, in terms of significant themes which were important within and throughout interpretations. The importance of a theme depends on how it gives meaning to experience and its relationship to other themes

within accounts, and is a qualitative judgement. It does not depend on the frequency of its appearance within accounts. (The analysis is essentially qualitative throughout. Accounts were variable, although they contained common themes, and a quantitative analysis of the frequency of themes would not do justice to this.)

Case studies were used in Study II, in analysis of the interviews with patients of general practitioners, in order to investigate in more depth how themes were linked within an individual's account and how an individual attempted to make sense of their experiences within their account. (These are discussed in Study II, Chapter Five; the value of case studies is discussed in Chapter Ten, Part III, Parts A and B). However, case studies were not used in Studies III and IV because the aim there was to integrate within interview analysis into across interview analysis, and to identify variability both within and between interviews and to identify commonality across interviews.

1. "Discourse" and the use of discourse analytic techniques.

Discourse analytic techniques were used to identify discourses used in accounts (see also Chapter Two, Study I) as a means of looking at how meaning is structured in accounts, using common linguistic resources or social discourses; for example, to identify the use of medical discourses in the analysis of patients' and health professionals' accounts. (This is discussed in Chapter Three, Part I, section 2.1.) The notion of discourse is used to look at a structure of meaning within speech or the text which is powerful in the structuring of an account. It is used in interpreting the construction of experience at a discursive level (*how* something is expressed in speech) rather than looking at *what* that experience is.

2. "Themes" and "Thematic Analysis".

2.1 The notion of a "theme"

Methodology was further developed to look at themes, to look at *what* was experienced and not only *how* accounts of experience are discursively constructed; thus attempting to look at meaning and subjectivity through looking at what experiences are, as well as the discourses in which accounts of experiences are constructed. The notion of a theme is thus broader than the notion of a discourse; it covers both experience and the interpretation of that experience. In looking at what experiences are described in accounts, the focus of analysis moves beyond the text, which is the focus of discourse analytic techniques, and is shifted to a focus on subjectivity as the ongoing experience of a person (see discussion of subjectivity, Chapter 3, Part I, section 2). The focus is thus on the person producing the account rather than on the account itself, and the account is taken as representational of their experiences (see Chapter Three, Part I, section 2.2).

2.2 The development of "Thematic Analysis".

In order to address the questions posed in the research a methodology was developed called here "thematic analysis", which can be characterised broadly as identifying themes within and across transcripts, using the notion of a "theme" as described above.

"Thematic analysis" has been developed drawing on grounded theory methods (Glaser and Strauss, 1967; Strauss and Corbin, 1990; Charmaz, 1990; Henwood and Pidgeon, 1994, 1995) and discourse analytic methods (Potter and Wetherell, 1987; Henwood, 1993). Several issues in grounded theory methods were particularly significant in the development of the research methodology :

2.2.1. The research began with general research questions, rather than tightly framed questions or hypotheses (Charmaz, 1990). Within each study in this thesis an overall aim or question is identified together with subsidiary questions, which alerted the researcher to areas of interest through which the overall aim might be pursued but which were flexible and subject to development through the data, and from which other approaches and questions might also be developed.

2.2.2. The research developed according to the emergent data, as questions were redeveloped with reference to the data, and issues opened out of the analysis of the data.

2.2.3. Theory was developed through analysis of the data as analysis moved from a descriptive to a more conceptual level, for example in linking themes and in the formulation of overriding themes as links were made between themes within and across transcripts, and as individual themes were themselves restructured.

2.2.4. Grounded theory methods were crucial in conceptualising the process of research, rather than providing prescriptive and specific research methods. They provided a set of analytic guidelines, which were useful in developing conceptualisations of the data as analyses developed through the research process and in identifying movement within the research process. This is vital since many qualitative research approaches are vague about methodology, relying instead on intuition (Charmaz, 1990), which leaves the process of developing methodology as uncertain and inhibits the development of a methodology which is validated through its own progress through the research data.

2.2.5. Grounded theory has been developed as a resource for deconstructive and reflexive analysis which includes (Henwood and Pidgeon, 1994) an acknowledgement of the researcher's own perspective and of the researcher as having:

- a) Substantive interests which guide the questions asked (here my interest in subjective experiences of depression and how these are expressed in language).
- b) Her own ideas and philosophical orientation to issues in the research (here my concern with depression as a non-pathological experience and my dissatisfaction with approaches to depression which conceptualised it as a clinical issue and as pathology, see Chapter One).
- c) Her own personal experiences, priorities and values.

2.2.6. Grounded theory was combined with awareness of discourse analytic techniques, in order to look at the construction of meanings of experiences within accounts. Discourse analytic techniques were used as developed by Henwood (1993) to move beyond the text and to look at how meaning is developed through interpersonal and socio-cultural contexts:

"In order to illuminate how the women's experiences may be rendered meaningful within their own accounts, local features of the interactive context, and wider systems of social, historical and cultural relationships." (Henwood 1993, p.306)

2.2.7. Methods were developed in order to foster an awareness of process (as in Charmaz, 1990), rather than a static or categorical analysis, thus following the basic tenets of symbolic interactionism, where self and meaning are seen as process rather than as static concepts and the emphasis is on experience as action rather than on the development of categorical and static forms of analysis. This also followed Giddens' (1979) theory of structuration (see Chapter Three, Part II, section 6 for discussion of this) where there is an emphasis on social process as incorporated into and reproduced by individual actions and subjectivity in a dynamic model.

2.2.8. The process of analysis included an approach to verifying or validating the themes, identified from within the data base. This can be seen as loosely analogous to grounded theory concepts of "constant comparison" and "goodness of fit", where similarities and variabilities are constantly compared across categories and categories are renamed as more data is placed within the category to improve the fit to that data, (Charmaz, 1990; Glaser and Strauss, 1967). Themes were validated by constantly comparing data within and across themes for variability and similarities, and themes were only as robust as they were able to include all excerpts identified within the theme. A

valid theme was consistent within the data base as a whole, and provided a significant new insight in interpretation.

2.2.9. There are however important distinctions between the methodology of thematic analysis developed here and the specific methods explicitly advocated in grounded theory (Charmaz, 1990; Glaser and Strauss, 1967).

a) The methodology used here was evolutionary and not a prescriptive methodology. Thus it was developed as a better approach to answering the overall research questions, as I became more experienced in handling the data.

b) The methodology was hence essentially flexible, and developed as new lines of inquiry became evident with familiarity with the data and as new methods seemed appropriate. For example, the methodology developed from identifying discourses to identifying themes, as the focus on the person rather than the text became more explicit.

c) The methodology aimed at an essentially exploratory rather than conclusive analysis. Emerging points of interest were followed up, and further questions developed. A comprehensive and conclusive analysis of the data was not attempted. There is no attempt to suggest that the analysis presented here is either exhaustive or comprehensive; what is presented is a possible interpretation of the data. Thus, although themes are validated with reference to the data, they are not seen as presenting the only possible interpretation of the data and they are presented here as representational, as present in the data but also as a basis from which further research could be developed.

For example, themes surrounding the use of a medical discourse, identified in Study II, Chapter Four, included the liberating effects of depression being validated as a medical or "real" problem and the stigma attached to the idea that depression is a form of mental illness. These themes were also developed through Study II (Chapter Five) and Study IV (Chapter Eight) and the strength of these themes depended on their being identified throughout the studies.

A note on transcription

False initials or pseudonyms are used throughout all excerpts, and all identifiers have been removed, to preserve confidentiality and anonymity. I am identified by name as the interviewer. Confidentiality was preserved since the data were not discussed in a form through which anyone could be identified and the transcribers were asked not to talk about their work and to stop transcribing if they recognised anyone's voice on the tapes.

Transcription was verbatim, with the use of normal punctuation, since the aim was to look at the content of accounts as representational of what a person experienced and its meaning for them, rather than the linguistic processes used in the construction of accounts.

Pauses are represented by a dash (-).

Omissions of data in excerpts are represented by (...). These occur where the tape was inaudible or data has been deliberately omitted from the excerpt as irrelevant to the point made, in which case care was taken to ensure that omissions did not alter the meaning of the excerpt.

More details about transcription, including costs and time, are given in Appendix B

A note on the use of interview excerpts in the thesis

Excerpts are presented to illustrate themes and discourses and to demonstrate how themes and discourses are structured and used in an individual account and throughout other accounts. Excerpts are presented as examples of themes and discourses and as such are representative. They do not represent all the various ways in which a theme or discourse might be used but attempt to show the significance of that theme or discourse within women's experiences. The excerpts from the interviews are rich and are interesting in themselves, and in the process of analysis and writing up the aim has been to provide a linking structure and draw attention to commonalities and variabilities in the data, as presented within the excerpts.

CHAPTER FIVE: STUDY II **EXPERIENCES OF DEPRESSION: INTERVIEWS** **WITH PSYCHIATRIC OUT-PATIENTS AND** **PATIENTS OF GENERAL PRACTITIONERS.**

INTRODUCTION

This study arose, firstly, from the observation noted in the introduction to Chapter Two, Study I, that there has been little scientific work on subjective experiences of depression nor systematic analysis of what depressed individuals experience and the meaning of those experiences to them; and, secondly, from the identification of the importance of the medical discourse in Study I (see Chapter Two). There it was noted that depression was legitimated and validated through the use of a medical discourse which was powerful in defining depression as an illness, as located in the individual, and as pathological. This was noted throughout the interviews in Study I, among a population who were not defined by reference to their experience of the medical system. Study II, presented in this chapter, looks in more depth at the impact of medical discourses as seen in accounts of experiences of depression in patient population, who had been directly exposed to the discourses of health professionals.

As argued in Chapter Two, little attention has been paid in social science research to the subjective experience of depression. A notable exception to this is Karp's work identifying the rhetoric or ideology through which patients attempt to make sense of their common dilemmas (1992), and looking at patients accounts of their history of depression and their careers as psychiatric patients' (1994). Karp (1994) draws heavily on the notion of a career, from a sociological perspective, and constructs a stage based account of patients' experiences and their adoption of identities as depressed and as patients. Karp (1994) developed a notion of "explanatory frameworks". This has been drawn on here in looking at ways in which patients do attempt to make sense of their experiences. The focus of the study presented here is distinguished from Karp's work (1992, 1994) because the focus is not on the notion of patients' careers but the broader aim is to directly address patients' experiences, how they identified their experiences as depression and how they accounted for and understood those experiences.

Part of this chapter appears in Lewis (1995).

PART I DESIGN AND METHODOLOGY

1. Aims

Overall aim: to investigate subjective experiences of depression among a patient population.

This study set out to examine subjective experiences of depression. The following were specific aims at the start of the study, issues that the research aimed to explore, which were further developed and refined through the processes of interviewing and analysing data:

1. To look at experiences of depression among a different population to that of Study I: patients who had been diagnosed as depressed, who had been exposed to the medical system, and were receiving treatment for depression.
2. To look at how individuals diagnosed as depressed understand the concept of depression.
3. To look at patients' experiences of the medical system and how that has affected their understandings of their problems.
4. In particular to look at the significance of the diagnosis in patients' understandings of their problems as depression, and to look at the significance to them of the identification of depression as a medical condition, for example the importance of labelling it as an illness.
5. To look at the significance of the pathologisation of depression in the diagnosis, and the effects of this on self-image and self-identity, as seen in the identification of the self as pathological.
6. To provide a more in-depth examination of the complexity of medical discourses as used in and by individuals receiving treatment for depression as patients.

2. Recruitment and procedure

Sample criteria and recruitment procedure.

The sample was to include both psychiatric out-patients and general practice patients.

Psychiatric out-patients

The aim was to interview 5 patients in-depth. This was not intended to be a representative sample since the aim was to look at variability and commonality in

accounts of subjective experiences of depression, rather than being concerned with experiences among a particular group.

Criteria:

The sample was selected by the patients' consultant psychiatrist according to the criteria supplied to him: the sample was to consist of volunteers who were both willing and interested in taking part in the project. They should also be articulate and willing to talk about their experiences. The ideal sample was to include both male and female patients, spanning the age range, with varied lengths of career as medical patients and with varied experiences of depression.

G.P. patients

Identical criteria were used for the selection of the G.P. patients, who were similarly selected by G.P.'s in a local practice for willingness and ability to take part, according to the criteria given above.

In both cases the G.P. or psychiatrist explained to prospective participants that I was a researcher at the university looking at individuals' experiences and understandings of depression, that interviews were to be relatively informal and that they were to focus on participants' own experiences and understandings of depression. They were to be tape recorded, but were anonymous and confidential. If the prospective participant expressed interest in taking part the doctor asked their permission to pass a telephone number or contact address on to me. I then contacted them, explained the study, again giving the above information about the purpose of the study and answering any questions they might have, and arranged a time for the interview.

Sample characteristics

A total of 6 psychiatric out-patients and 3 G.P. patients were interviewed. Of the psychiatric out-patients, 5 were male and 1 female, and of the G.P. patients 1 was female and 2 were male. The distinction between the general practice patients and psychiatric out-patients was not in any case clear cut. One general practice patient (John) was also receiving treatment as a psychiatric out-patient. Another (Angie) was currently seeing the G.P. counsellor but her G.P. was also arranging for her to see a clinical psychologist.

Brief biographies

Psychiatric out-patients:

Douglas: He was in his early seventies and had retired from an active life as a trade unionist, J.P. and voluntary worker in the community. He was clearly very capable and intelligent and was someone who had striven to make the most of his opportunities. He was married with children and grandchildren and stressed the importance of his family. His experience of depression had coincided with his retirement. He was reserved but friendly in the interview, and clearly frustrated by his experiences and the fact that he could not understand what had happened to him.

Eric: Eric was in his late fifties and described himself as suffering from "nerves", since he shook or trembled uncontrollably. He could cope with his family but any social occasion was a cause of great anxiety. He described this as a life long problem but one which he used to be able to control. He was not in work, but this did not figure as a big issue in the interview. He was worried about family problems, his son's marriage and his wife's health, and felt that these aggravated his nerves. He also stressed the value of his wife's support. However, during the interview he was not noticeably shaking and seemed relatively relaxed and forthcoming.

Chris: Chris was in his mid-forties. He had been a skilled construction worker on oil rigs, and had decided to retrain so that he could work in his home city and in a more secure job. He had started a management course when, after a term, he had been struck down by what he understood at first as a physical illness, like 'flu. He had not recovered from this after several weeks and experienced extreme tiredness and lethargy. His initial consultations had identified no physical cause and he had then been referred to a psychiatrist and depression was diagnosed. He was married, his wife had been very supportive and as she was still in work he said that they had no great financial worries. The impression given in the interview was that he was puzzled and frustrated by what had happened and that the medical diagnosis had not resolved this for him. He was ambivalent about the appropriateness of a medical diagnosis of depression. He was clearly very intelligent, was forthcoming in the interview, and very reflective.

Frank: Frank was in his mid-fifties. He suffered from what he described as anxiety and depression. He related this to a history of financial disasters, backing a business for his daughter which failed, then the loss of his own job and his wife's. He attributed his experiences of anxiety and depression to unemployment, and said that he would be OK if only he could get back to work, which he was desperate to do. He worried greatly about his circumstances. Part of his difficulty seemed to be filling his time since he had

lost the ability to pursue his old interests, including caravanning and car restoration which had been the love of his life, because he could no longer afford them. He brightened up visibly when talking about his previous life and hobbies when in employment, which appeared to have been busy and relatively care free. He described a present life of extreme and continuous anxiety and isolation, unless he was able to get into conversation with people when his worries were temporarily alleviated.

Martin: Martin was in his forties. His experience of depression had followed what he described as a nervous breakdown. During the interview he said that he was a lot better than he had been, but lived in fear of depression returning. He described depression as an horrific experience, which came on suddenly and which he could not explain. It was very different from the everyday experience people described as "feeling depressed". He was clear that it was an illness and that he was recovering due to and needed medical help. He described depression as feeling totally confused and unable to cope with life, and said that he had also lost all his confidence in himself. He had given up work, and was now isolated, since many of his friends now avoided him. He also emphasised the support his wife had given him.

Geraldine: Geraldine was in her early fifties. She described herself as feeling depressed for the past six months, and believed this might be due to the menopause. She described it as something which happened suddenly and for no reason and which lifted as fast. She was also on lithium, but did not relate this to any diagnosis of depression. Hers was the shortest interview and the most difficult since she was not very forthcoming and I obviously did not succeed in putting her at her ease. She was, however, quite clear in what she said, and I think probably either did not wish to or could not discuss things in a more reflective way.

General practice patients: see later (Part III).

3. Interview design

The interviews were in-depth, semi-structured interviews. The aim was to allow participants to freely express their own experiences in the course of the interview, and the format of the interviews was as flexible as possible in order to allow this.

An interview schedule was used (see Appendix C). It focused on three broad areas: the participants' identity, their sense of self and their important relationships in everyday life; any key emotional experiences and ease of talking about these; any specific experiences of depression, how they identified depression, and anybody else they knew whom they would describe as depressed. This schedule aimed to provide a broad

framework for the interview and to look at individuals' experiences of depression in the context of their lives, and of other personal and emotional experiences, and to investigate understandings of depression more broadly through looking at experiences of depression in other people. Participants were shown the schedule for information, but were not asked to address themselves to it, and having seen it most participants put it to one side.

The use of the schedule was to provide broad guidelines for the interviewer on possible areas to be covered, rather than to dictate the form of, and questions asked during, the interview. The schedule was available to provide prompts for the interviewer. The aim, however, was to focus on the participant's experiences and what they understood as important, and to follow up their interests in the course of the interview. The schedule was also adapted throughout the course of the interviews since it became evident that some areas were regarded as more important than others. In any case, the aim was to address the patients areas of interest and their perspectives on their own experiences as much as possible. (See Chapter Two).

It was characteristic for participants at the beginning of the interview to express their concern that the interviewer would be directing the interview by asking them questions. However once the interview had begun they were forthcoming about their experiences, and there was little need for prompting. In practice although the schedule provided prompts for broad areas, of interest to the interviewer, there was little reference to it in the course of interviews.

Interview procedure

Interviews lasted between 45 and 90 minutes.

Interviews with psychiatric out-patients were in the hospital out-patient department after the patient's appointment with their psychiatrist. I introduced myself to the participant before their appointment, and arranged to meet them afterwards. Interviews were conducted in a small interview room, in the psychiatric out-patient department at the hospital, which as far as possible within an institutional setting provided a more relaxed atmosphere. I emphasised that I was not a doctor nor health practitioner nor in any way connected with the hospital but a researcher at the university, since I did not want participants to feel unnecessarily constrained in what they said nor to think that I might be involved in hospital treatment. Inevitably their recent appointments with their psychiatrist might affect the content of the interviews, but on discussion this arrangement was the most practical arrangement for most participants.

Interviews with the general practice patients took place in a small room in the psychology department of the university for the male patients, and for the female patient in her home, since she had a baby. Again, I emphasised that I was a research psychologist, with no connection to the patient's general practitioner, and that I was concerned to hear their accounts of their experiences as they saw them.

Interview process

There were three phases to the interview process, as discussed in Chapter Two, Part I: a warming up phase, the main phase and the winding down phase. In the warming up phase I focused on asking patients about how they had travelled to the hospital, and procedural issues such as how much time they had available and whether they had anyone waiting for them. I again broadly outlined the study, explained who I was and my interests in hearing their own accounts of their experiences of depression. I again explained that interviews were to be tape recorded, that they were anonymous and confidential and that all identifiers would be removed from the transcripts, and confirmed that the participant was still happy to have the interview tape recorded. The tape recorder was then switched on.

I then moved on to asking them how they came to be receiving treatment as hospital out-patients, although in some cases participants themselves moved into talking about their experiences of depression once I had outlined the study.

In the winding up phase, which was initiated either because the participant had come to a natural end point in the interview or because time was running out, I brought the discussion to a conclusion and asked the participant if they had anything they wished to add and how they felt about the interview. I thanked them for their time and participation and confirmed that they had my telephone number in case they had anything they wished to say later, although nobody did in fact contact me.

Transcription

The interviews were transcribed verbatim, as in the exploratory study, some by myself, others using secretarial support (see Appendix B for further details).

4. Analysis of interviews: The development of "Thematic Analysis".

"Thematic analysis" was developed by the researcher from an awareness of discourse analytic type methods (Potter and Wetherell, 1987) and reading on grounded theory (Henwood and Pidgeon, 1994; Charmaz, 1990), as described in Chapter Four. It aimed to look both at the experiences individuals were describing and at the language they used to describe them, as indicating the meaning of those experiences. More details about the mechanics of the methodology are given in Appendix B.

The method was developed by the researcher through experience of analysing data and to specifically answer the research questions. During interviews, the importance of some issues became evident and themes initially began to emerge through reading and rereading the transcripts. The aim was to analyse on both an across interview and a within interview basis, identifying patterns between interviews while maintaining a focus on the individual interview and on meanings constructed within the individual interviews. The methodology of "thematic analysis" aimed to fulfil both these criteria.

4.1 Out-patient interviews:

Stage 1 Initial reading and analysis on an individual basis

The method devised was initially a repeated reading of all the manuscripts. From this basis themes in experiences and in discourses were initially identified, on an individual basis. In looking at the themes in individuals' experiences a method which borrowed from the systematic approach of grounded theory was used.

Themes were identified within interviews and excerpts from the interviews were categorised as within those themes. The themes developed as more excerpts were identified, and sub-themes were also developed. Themes were also linked, in processes analogous to the grounded theory methods of constant comparison and goodness of fit (Charmaz, 1990):

- a) Constant comparison. The data within themes was constantly compared as themes were built up and themes were linked and relationships identified between themes. This led to the identification of linkages between themes which moved the analysis from a more descriptive to a more conceptual level.
- b) Goodness of fit. The validity of the data for a theme was constantly reconsidered and themes were reconstructed throughout the process of analysis, and links and possible contradictions between themes in the interviews were

explored. The aim was thus to identify important features in accounts within interviews, and this included both looking at issues in the ways in which those accounts had been constructed and at experiences described by the participant.

Stage 2 Analysis across interviews

Once themes had been identified within interviews, on an individual basis, the themes identified in the individual interviews were compared, looking both for similarities and for differences. This process also used the notions of constant comparability and goodness of fit as described above. The aim here was to:

- i) Identify themes which were common across interviews, in order to look for common experiences and interpretations across experiences, inductively discovering repeated patterns in accounts of experiences.
- ii) To identify variability as shown between interviews, since the aim of the study was not simply to look for commonalities across interviews but to look at the complexities of accounts. This included looking at the different themes across individual accounts, and variability between individuals' subjective experiences and their interpretations of those experiences. Given the perspective on depression as the experience of a person adopted in this thesis (see Chapter One), it was critical that the study retained its focus on the individual and incorporated this into across interview analysis.

The movement between stages 1 and 2 is particularly important in illustrating the repetitive and recursive nature of analysis. The power of a theme depended on its particular function and position within an account. This could also only be understood within the account as a whole, on a within interview basis. But the across interview analysis was vital in illuminating the presence of recurrent themes which could be identified as appearing across interviews, and which were powerful across individuals' interviews as well as within a particular interview. The across interview analysis was vital in identifying similar features in the experiences which individuals identified as depression, and similar themes in their interpretations of their experiences. Thus the themes of loss and loss of identity were strengthened by, and in some interviews emerged from, a consideration of themes across interviews.

The across interview analysis achieved two objectives, in enabling a reconsideration of the within interview themes and in beginning to identify a common framework in the ways in which individuals structured their accounts, for example identifying common themes in experiences of depression, their interpretation and the meaning of the term

depression. The use of both across interview and within interview analysis was necessary in identifying variability in the ways in which a theme was constructed by different individuals, and variable meanings of discourses and themes for different individuals or for the same individual at different points in the interview. The depth of analysis was dependent on both within and across interview analysis.

Stage 3 The relationship between themes

The process of linking themes continued and was used to generate a more theoretical perspective on the data. This incorporated an awareness of the meaning of the data at an individual level as well as of the relationship between themes identified within individual interviews. Basically, it involved the linking of themes in order to inductively develop a conceptual framework from the data (Charmaz, 1990).

The relationships between themes were critical in identifying how different themes might be used in different ways by individuals, and how different themes and discourses linked together.

For example, the medical discourse of depression as an illness and the theme of rational accounting for experience were linked, since the medical discourse was powerful in labelling and defining what was otherwise a mysterious experience when individuals could find no reason for their experiences of depression. See, for example, **Part A section 4**, the mystery of depression, where individuals reject or accept the diagnosis of depression on the basis of the availability of a reason for it located in their lives.

For example, themes of the medical discourse of depression as an illness, and of rational accounting for depression in terms of reasons located in life experience, can be seen to provide alternative accounts of depression linked to a life event or of depression caused by a biochemical malfunction as in the medical model. These are seen in **Part A section 3.1**, uncontrollable biochemistry, and **Part C section 2.1**, unemployment, loss and lifestyle. Participants developed themes in interviews and themes were developed in relation to each other. Themes might be used as alternatives, for example, depression was understood to be biochemically caused when an individual could not give an account of life experiences which fully or satisfactorily explained depression, (see for example **Part A section 3.1**, uncontrollable biochemistry). Themes might be overlapping or used in conjunction with each other, as in the idea that depression is an illness, and as an illness it is caused by the stress of unemployment (see **Part C section 2.2**).

Although the analytic process has here been described in stages, in practice it was a recursive process, since the establishment of links between themes might also lead to the reconstruction of initially identified themes. It might be best understood in terms of the data analysis moving from a descriptive to a conceptual level. There was no clear movement in the practice of analysis from one stage to another, although different concerns informed the development of the analytic method as the analysis moved forward, such as the need to develop a conceptual framework within which to present the data and make sense of the data in the research account.

4.2 General practice patient interviews

The process of analysis used here was basically the same as that used in the out-patients' accounts, with the important difference that after the initial analysis and identification of themes within interviews as described in stage 1, above, stage 3 was redeveloped retaining an emphasis on the individual account.

The data are therefore presented on a case study basis. This is because the preliminary analysis of the interviews suggested that, while there were some common themes in the interviews, there were also major differences in the themes which emerged from the individual interviews. There appeared to be less commonality between interviews with general practice patients than for those of psychiatric out-patients, at least at the early stage in the analysis. These differences between general practice patients' interviews appeared to warrant a case study approach, which retained the focus of analysis on individual accounts in order to show the variability and integrity of these accounts, to explore the complexity of individuals' accounts, and to explore and present in the research account linkages between themes on an individual basis.

PART II RESULTS: PSYCHIATRIC OUT-PATIENTS

The data analysis is presented in three parts:

Part A. What is the problem? looking at whether and how individuals interviewed identified their experiences as depression.

Part B. Experiences of depression: looking at what individuals experienced as depression.

Part C. Explaining depression: explanatory frameworks; looking at how individuals explained how they came to be depressed.

PART A : WHAT IS THE PROBLEM?

This section will look at how individuals identify their problems as depression. The medical diagnosis of depression is central in identifying problems as depression, and the diagnosis often serves to identify experiences as depression which are otherwise a mystery to the person experiencing them. In this respect the diagnosis is potentially liberating, since it recognises and places experiences within boundaries of the known (Karp, 1994). The diagnosis may also be experienced as liberating since the problem of depression may then be understood in biological and biochemical terms, which suggest that the individual person is not responsible nor blame-worthy. Recognition of depression as a medical problem in the diagnosis also offers a potential hope of resolution.

However, the diagnosis is also stigmatising and this makes it difficult to tell to others, and may drive others away, increasing the sense of isolation experienced in depression. The diagnosis is seen as pathologising and, although potentially liberating, in social terms it identifies the individual as an abnormal or deficient person.

The pervasiveness of the medical discourse, of depression as a medical problem and as an illness, may be explained by the fact that depression is a mysterious experience. The medical diagnosis of depression as an illness provides recognition and limitation of the problem. However, it may leave the individual feeling dependent on the medical system for control or cure, although this hope is not necessarily fulfilled.

The diagnosis of depression was surprising for some participants, since they had not identified themselves as depressed until receiving the diagnosis. Some accepted the diagnosis but there is also evidence of considerable ambivalence over the appropriateness of the diagnosis of depression, for example in the interviews with Chris and Eric. The analysis also looks at how individuals incorporated the diagnosis of depression into their sense of identity, and at whether they saw themselves as

depressed. It suggests that the diagnosis might serve to both distance the problem of "depression" from the self, as an issue of control and responsibility, and at the same time pathologise the individual. Part C of this analysis will consider the extent to which depression was constructed within accounts as a problem of the self or explained with reference to external situations.

1. The diagnosis : identifying the problem.

Douglas spontaneously identified his experiences as depression in the interview. This was a label given to him by his G.P. and then his psychiatrist. He is seen to have accepted it and to use it to give his experiences a name, although not necessarily a meaning:

Siân: Would you say you were depressed or did the doctor say it?
Doug: The doctor who visited said so you know.

Martin also categorically defined his problem as clinical depression, and defined himself as depressed:

Martin: I'm defined as clinically depressed - clinical depression.

He talked of earlier experience, which he described as a nervous breakdown. He categorically defined his subsequent and present experiences as clinical depression, following the diagnosis given to him by his doctor. Clinical depression was identified as the cause of all his symptoms:

Martin: But the later things what's happened to me I know is depression. Getting up crying in the morning - and not sleeping - and things like that - and panic attacks. The doctor says it's all down to depression like - it is clinical depression.

Frank also identified his experiences as depression. His doctor suggested he suffered from anxiety and depression. He has no other way of thinking about his experiences, and he would call himself depressed and anxious:

Frank: I would, anxiety and depression - aye, anxiety and depression - I do aye. I can't think of owt else.

2. "Real " depression.

"Real" depression may be conceptualised in terms of illness, as distinguished from everyday experiences. Martin suggested that real depression was severe depression such as he has experienced. It is a very different experience to that meant when people say, in everyday conversation, that they are depressed and is incomprehensible to most

people, since it is so different to what they have experienced themselves. Similarly, he was only able to identify his experiences as depression through the diagnosis, where "depression" has a specialist meaning which was very different to how he had understood the term depression in popular usage.

Siân: Would you have thought it was depression anyway?

Martin: No. Because people don't know what depression is. People that use the term depression, most of the time - 'I'm a bit depressed' - and they don't know what true depression is do they. And this is it, see. And I didn't - it were new to me.

Martin suggests that part of the problem in communicating about experiences of depression may be that depression is very different as an everyday experience, which the term "depressed" is commonly used to describe, from the experience of severe or true depression, which he understands as a medical condition. He would not use the everyday terminology of "I'm depressed" to describe how he now feels.

Martin: And that's what it is - until it happens to you, you don't know nothing about depression. They make me laugh people - 'fugh I'm depressed'. You don't know what it's about. Because true depression's horrible.

Siân: Would you have said that before?

Martin: No - I didn't understand it.

Siân: Would you have used the expression 'oh I'm depressed'.

Martin: Well, sort of, yes - because everybody says it don't they like. But they don't know the meaning of a true depression.

Siân: Would you use it now?

Martin: 'I'm feeling depressed'? No. I don't, no.

Chris also suggested that he was only able to understand his problems as depression through the diagnosis, and that previously he would have had no understanding of the meaning of depression as a medical condition. But this leads him to question the appropriateness of the diagnosis:

Chris: Mind you, I've been told that what I've had is depression, yes. If somebody hadn't told me it was depression, I wouldn't have been able to say what I thought it was or how it effects you.

The severity of experiences of depression is not easily recognised by the public, and sufferers experience their problems as hidden from, or denied by, others. Other people simply may not think that they are depressed. The medical diagnosis is therefore needed in order to identify and validate problems. It may be particularly pervasive because as expert knowledge it confirms the individual's experiences in the face of denial by others. This was suggested in an excerpt from Douglas, who had been diagnosed as suffering from depression but believes other people would not recognise this:

- Doug: I don't think people would think that I was depressed but I certainly am. There's no doubt about that.
- Siân: Would you say you were depressed or did the doctor say it?
- Doug: The doctor said it, the one who visited.

3. Biological problems

3.1 Uncontrollable biochemistry.

An understanding of depression as biochemically caused may be implicit in the diagnosis of depression as a clinical condition. This is pathologising in terms of individual biology. But it is also experienced as liberating. It establishes that the individual has no control over their experiences and advances an explanation for depression. The individual is absolved of moral responsibility and at the same time it is made clear that they themselves are not accountable. Depression is something which has happened to them. For example, Martin:

- Martin: But I can understand it when they said 'clinical depression' - that it's summat, chemical reaction you know. And I thought at first that I can have some control over it. I tried everything to try and combat it. But if it's a chemical reaction I realised I couldn't.

The biochemical model removes the concept of depression from a moral framework of personal responsibility and contextualises it in terms of biological pathology. This explanation of depression as biochemically caused may be maintained even when drug therapy has been unsuccessful or is minimal, partly since it is given with the full authority of medical knowledge. It is notable that Martin understands his experience of depression as a biochemical problem, potentially controlled by drugs, despite his experience of anti-depressants which have not worked for him:

- Siân: Did you say you think it is chemical?
- Martin: I think so - that's what I was told at X [name of hospital]. John Anderson [psychiatrist] in charge of me up there - and he says it's a chemical. Clinical depression is that - it's chemical.
- Siân: Did you say you're not on anti-depressants now?
- Martin: No, I've been on various types - and never never did a thing. And he wanted me to come off them like. And I came off them - and all I'm on now - is just a relaxant like - I can never think of names - it's like Largactil. I know that if I don't take it - I don't get a relaxed sleep. I've been paranoid about that - getting sleep.

The biochemical model may be particularly powerful in explaining the physical effects of depression and in identifying that the problem is depression at all. Chris was ambivalent or rejecting as to the appropriateness of calling his present experiences depression, but suggested that they might be explained through a biochemical model of causation:

- Siân: What about this tiredness thing do you think that's depression?
 Chris: Well, that's the part I can't understand. You know, that's to me... I don't know how it's related. Mind you from what I've read there's supposed to be some chemicals in the brain or something you run short of and that causes your depression, but from what I understand doesn't that also effect you physically?

3.2 Uncontrollable hormones

Women's experiences of depression may also be understood in terms of the female lifecycle, and of female reproductive biology. The concept of female hormonal vulnerability is seen in a popular discourse which locates women's problematic experiences around points of change in the female reproductive cycle and which identifies depression as a hormonally caused. Geraldine had a long history of experiences of depression and of treatment with lithium. Despite this, she understood her recent experiences as possibly connected to the menopause, and as a medical problem.

- G'ine: Well you know I'm fifty four, so it could be having change.
 Siân: Yes.
 G'ine: That could cause it. You know, but Janine [her daughter] says, "Promise me Mum that you'll go to doctor's and tell him how you feel".

4. The mystery of depression

Depression is experienced as a mystery, something for which it is difficult to identify a reason. For example, Chris has no reason to feel depressed which he can identify. At the onset of his illness, which appeared with 'flu like symptoms, he was on a retraining course, which he saw as increasing his employment prospects. His illness is a mystery and this is incompatible with his understanding of depression, since he believes people become depressed for a reason.

He feels that he himself has no reason to be depressed. His son, who had been engaged to be married, had been depressed when the engagement had been broken off. That is a real reason to be depressed:

- Chris: Now I'd have called him depressed, you know... you knew the reason why he was like that. That's something I can't understand... from what I could see I'd got nothing to lose, you know, because I was at college learning something that, hopefully, was going to make me a better future, and all of a sudden depression.

People feel depressed and the concept of depression as an illness suggests that there is something wrong with them. The lack of an identifiable reason may explain why the diagnosis of depression as an illness is so tenacious. The idea of depression as an illness

may be powerful because the occurrence of depression is experienced as a mystery. Individuals have no reason which they can identify as sufficient to account for their depression and therefore it is seen as problem with themselves. Implicit in this is the idea that you need a reason for depression in order to be able to account for it in terms which suggest that there is not something wrong with the individual person, and in order for it to be acceptable or normal. Conversely, feeling depressed without a reason must be a problem with oneself, a sign of deficiency.

Depression is an unaccountable mystery for Douglas, who can see nothing over which he should be depressed:

Doug: I get depressed about nothing. For no reason whatsoever you know.

Geraldine suggests that she has everything which she might want and that she has no need to be depressed. She suggests that depression has a function and that it fulfils a need, but that for her it is an unaccountable reaction and a mystery:

Siân: Do have any idea why you might get depressed sometimes?

G'ine: No. Just comes on. Just comes on. That's why I want to talk about it. It just comes on out of the blue.

Siân: Yes.

G'ine: I've got a lovely home. I've got a smashing daughter and a good husband - so I don't need to get depressed...

These interviews with psychiatric out-patients also suggest that the diagnosis has not resolved the mystery of depression for them. It is still an experience which participants are unable to account for or to make sense of. The diagnosis has, however, removed the problem to the medical sphere, and given it an identity as a specialist and medical problem.

5. Ambivalence towards, or rejection of, the diagnosis of depression

Two out-patients rejected or were ambivalent about the appropriateness of the medical diagnosis of depression. The diagnosis was incompatible with their own understandings of their experiences. Eric rejected or ignored the diagnosis, instead understanding his problems as caused by his "nerves". Chris was ambivalent since although he had physical symptoms, he did not at the time of the interview feel low or depressed in the common sense of the term and he believed he had no reason to feel depressed (see also Part III, 2.1). He rejected the idea of depression or mental illness but not that of a physical illness and thought, for example, that he might be suffering from ME, since the symptoms he identified were in the main physical rather than psychological.

Eric understood his problems as his "nerves". This use of a popular discourse may be an attempt to make his problems more acceptable to himself and others. By avoiding medical language he may have been attempting to establish his problems as a common complaint. This might avoid the stigmatisation associated with the clinical condition of depression understood as a (mental) illness.

Siân: So you wouldn't say it was depression?

Eric: I don't know what it is. I just don't know. It's bad nerves and that's it. Funny nerves.

He may also be uninterested in the diagnosis since it cannot resolve his problems, and his real interest is in his daily experiences. He attempts to cope with them by avoiding difficult social situations.

Siân: Would you call it depression, or-?

Eric: I don't know, just let me keep out of the way.

Chris rejected the diagnosis of depression as a description of his present experiences. He suggests that he cannot be suffering from depression now because he does not feel depressed as he understands the term: he feels sociable and interested in life, which is incompatible with depression as he understands the term. This is in contrast to how he felt at the start of his illness.

Siân: Would you say it was [depression] now?

Chris: No, I don't think so, now I think I've, well it can't be because I mean, you know how I was to start with I wouldn't talk or anything you know, I didn't want to meet people or anything, I didn't want to go anywhere, see anybody, you know just.- Now I'm alright.

During the interview he reflected on whether his experiences were depression. Although at first he rejected the diagnosis of depression, in reflecting upon his experiences and how he had felt he became more ambivalent. He suggested, while reflecting on his past experience, that he might have felt depressed then.

Siân: And do you think they're right when they say it's depression?

Chris: Yes, yes. Yes, thinking about it, when I first started I think it was yes.

However, even if he was depressed in the past he is mystified by his present experiences, in particular because he still has physical symptoms which he cannot alone equate with depression, and believes that how he feels and his behaviour has changed from the beginning of his illness.

Chris: Yes, I'd say something but-. I think if somebody asked me something, it was an effort, you know, like, to drag it out of myself. You know, really hard work to talk to anybody, even my family. But that's, that's better now. I suppose then I was depressed, you know, what you'd call depressed but as I am now I, I've come a long way from that yet I've still got these symptoms, that's what's getting me.

He goes on to suggest that he does sometimes feel low but that the cause of his present problems is his physical symptoms. They, and not depressed mood, are the real problem. At this point he is ambivalent as to whether or not this is depression:

Chris: You know, it's- As I say, sometimes I feel low and fed up and its because I feel like this more than anything.

Siân: Would you call that depression or?

Chris: Er- I don't know, it's- I don't know, it's- I don't know.

He questions whether the diagnosis is appropriate:

Siân: Do you think it's depression or not?

Chris: Well, I don't know, I don't know.

6. The stigma of mental illness

Although the diagnosis of depression may be experienced as liberating, in that it provides recognition of and puts boundaries on the problem and potentially, within a medical framework, offers the hope of resolution and cure, it is also stigmatising.

The diagnosis is difficult to talk about. Participants suggested that they had difficulty talking about depression, even to close friends and relatives. The availability of a diagnosis does not make it any easier to tell people what they are suffering from.

For example, for Chris the diagnosis of depression was a shock. He saw depression as something which happened to other people. He has difficulty telling his wife:

Chris: I think really I was quite shocked and I didn't know how to tell my wife. I had to pluck up courage to do it, you know. Because you hear about people with depression, you don't think you're one of them.

The idea that depression was the experience of "other" and was not normal was prevalent as participants described their sense of isolation, their relationships with others, and the difficulty they had in talking about their experiences. This sense of "otherness", of depression as something abnormal, was reinforced by the diagnosis of

depression, which was open to interpretation as a diagnosis of mental illness and therefore stigmatising.

Douglas, for example, said depression was difficult to talk about because people saw it as akin to madness:

- Siân: It's funny, isn't it, because people do feel depressed but nobody talks about it?
 Doug: Yes, I'm sure that's, I can understand it quite honestly. It's not something that we can really talk about.
 Siân: Yes, I think that's true. Because you don't want to or because?
 Doug: That's right, they think you're strange or something like that- loony for want of a better word.

Mental illness is not accounted for in the same terms as physical illness. The identification of a person as mentally ill is damaging and comes to identify the person as potentially mad. Part of the difficulty in talking about depression is that it is an experience which it is difficult to put into words, and this may reinforce the sense of difference, of "otherness".

- Siân: Is it- because it's something that is difficult to put into words anyway?
 Doug: Yes, partly that and partly I think you get a feeling that somebody, because it's mental, think that, now what do they think? Sometimes, how to explain that, I think that being mentally ill is different to being physically ill- and I think that probably people have an idea that you're not altogether there, for want of a better word- I don't think that most people think that way but I'm sure that some do think that way. And I think you worry about that too.

Hence medicine may be seen as a safe haven. Douglas could tell his psychiatrist how he felt but not his wife, since he was afraid of frightening her. In this sense medical care may offer the opportunity of asylum, a place of safety.

- Doug: I don't mind coming here, you know, talking to Dr. Wright, get it all out as it were. He sits there and listens. I wouldn't do that to anybody else, I don't tell the wife and that.

Martin had rejected the idea that he was mentally ill. Again it is a label of "other" which he does not apply to himself. It is stigmatising and this is not how he sees himself. But he believes that it does determine how other people see him, and means that they are frightened.

- Martin: Yeah. -But just because it's summat - mental illness if you want to put it that way - I've never classed meself as being mentally ill, like, you know. I suppose it comes within that category, like, you know, but - but

I've never classed myself being mentally ill, like. But they're frightened of it - that's, put it that way.

Mental illness is stigmatising, a label which it is not easy to overcome and which shapes one's social identity. The experience of depression may be one of rejection by others, of isolation and of stigmatisation. Martin, for example, found that since his stay in a hospital for mental illness he had been avoided and rejected by people he had previously considered his friends.

Martin: And I've had people - when I used to be going at work - and they shun you - and that hurts - people I've known for fifteen year - and they see you coming - and they avoid you because it's summat they're frightened on. They know what you're suffering with - and they don't know what to say to you. It's like somebody when they've had a bereavement - and people react different - some people shy away from it.

Siân: It must make you feel awful.

Martin: It does, yes. It did - because I would class them as good friends - and they didn't want to talk to me - because they didn't understand me. They think that if you've been in X [local hospital for mental illness] it's got a stigma, stigma to it.

Alternative constructions of experience, to that offered within the terms of a medical diagnosis of depression, may attempt to place it outside the medical discourse and within the framework of a more popular discourse. Eric has been unable to explain his experiences to other people, partly because he is afraid of being seen as mad. An alternative construction of his problems as his "nerves", may protect him from the idea that he might be mad: it is his nerves which are the problem not himself:

Siân: Have you ever tried to explain it to other people?

Eric: Oh no. Because they like think you're crackers. I always think that. They'll think "What's he talking about? He shouldn't be saying daft things like this." And I always think they might think you're round the bend or something. Which I might be in a way.

Siân: Well, it doesn't sound daft to me actually.

Eric: I might be round the blooming bend in some ways but if it weren't for nerves I'd be alright. I don't do daft things, don't get me wrong. I don't do daft things. But it's just facing up.

7. "Pull yourself together!"

Within interviews it was suggested that the depressed person is either dismissed or stigmatised by others. Depression is something which people find it impossible to relate to. Either the person has no real problem or they are pathologised as an inadequate person in psychological and social terms. Martin suggests that people need to be able to recognise and themselves relate to depression before they can sympathise with it as a real problem. Because there is no physical evidence of depression it may be assumed that there is no real problem.

Martin: If they see you walking about - you haven't got a pot on your head. If you've got a pot on your head - and they can relate to it - you've got it made. But when you're suffering from depression - and they see you about - and you're talking alright - same as I'm talking to you, alright - they don't understand - 'there's nothing wrong with you' they think.

Siân: Could you explain to other people?

Martin: I've tried. But they just don't understand, I don't think.

One of the problems in experiencing depression is other people's behaviour. Martin thought that depression is not tolerated, since people do not want to understand it. There is in general no attempt to empathise with depressed individuals, and there is a total lack of understanding because, he believes, most people have not experienced depression.

Siân: If you had the chance to sort of broadcast something about it - what would you say, what would you want them to understand?

Martin: Yes. Difficult un that.- More what I want people to understand - is just more people are going through like - what is happening to them - and trying to be a bit more understanding. Because they say to you things like 'shake yourself, pull yourself round' - and you can't-. And I would want people to be more tolerant - but they don't you know. They're OK - they're getting on with their lives - I don't think they're bothered.

Siân: Like they can't understand.

Martin: No, they don't want to. That's top and bottom of it. Till it happens to you - and then you have to have all the sympathy in the world.

Eric similarly thought that people ignored or failed to understand the real problems which he had, and saw him as unsociable:

Eric: I think they know about me with the nerves, her sister, because she'll say he shakes a lot, but I think half of it they think you're being mardy and funny and awkward.

8. Summary

The diagnosis can be seen as critically important for patients in identifying experiences as depression, in validating those experiences as real problems, and in providing recognition and acceptance of those experiences. This suggests the power of what can be defined as a medical discourse, which defines depression as an illness and validates and legitimates problems as depression.

As such the diagnosis is potentially liberating, since in identifying the problem it confines it, and in validating the problem as one which is known and recognised it offers hope of resolution. This is consistent with Karp's (1994) analysis of accounts of subjective experiences of depression, where the diagnosis was identified as a turning point, a point of validation, and experienced as liberating. A potential explanation for

depression may be offered in terms of a biochemical deficiency which, since it explains the problem in impersonal terms, removes the idea of personal responsibility and control and the idea of a deficient self. In this respect medicine may offer a haven since depression is an acceptable problem within the medical framework. However, at the same time the diagnosis is pathologising and may leave individuals feeling dependent on medical treatment, management and control.

Depression is socially stigmatising. Other people may be intolerant of the depressed person's changed behaviour, which they cannot understand and for which there is apparently no reason. The diagnosis of depression is itself stigmatising and may reinforce difficulties in talking about depression, since depression is seen as mental illness, an abnormality, and carries with it a sense of "other", of personal, social and psychological deficiency. Behaviour of others towards the depressed person may reflect wider fears of mental illness. This may contribute to problems of depression, since part of the experience of depression is a sense of isolation and apartness.

PART B : EXPERIENCES OF DEPRESSION

This section will focus on the problem of living with depression, as part of daily life. It will look at how individuals describe their experiences of depression and the meaning of those experiences to them. Participants found it hard to describe their experiences, emotions and feelings in depression. This section, while noting this, attempts to look at the implications for them of their daily experiences, and in particular how they incorporated experiences of depression into their sense of self and how the change in their experiences made them feel about themselves.

Depression was experienced as something which happened *to* people. Individuals felt unable to manage their feelings and behaviour and in particular experienced a total loss of motivation, which was frustrating and inexplicable. This constituted a changed and puzzling experience of self, and can be understood as a loss of self. Individuals described themselves as avoiding engagement with others, as unable to become involved in activities of daily life, and as experiencing a total loss of confidence. Coping with day to day life in itself became a huge problem. There was also little indication that participants felt much hope of resolution.

1. An indescribable experience.

Most participants were not able to describe the experience of depression. It was said to be an experience which it is difficult to put into words (Lewis, 1992, 1993).

Depression was described as a qualitatively different experience. There appears to be no available discourse to describe it. Partly this may be because the feelings are so strong, partly because it is a confusing experience in itself, and partly because it is an experience it is simply difficult to tell someone else about. Part of the problem in talking about depression may be that it is stigmatised, as suggested above (Part I, section 6), and is an experience of “other”. It is an experience which is not incorporated into the framework of everyday social discourse.

The experience of depression is difficult to make sense of, to oneself as well as to others. The feelings experienced are overwhelming. For example Douglas, who was very articulate throughout the interview, said:

Doug: Its difficult to explain- I don't think I can really fully explain it- fully to express, you know, what you just do feel like. You feel so low, dispirited and worry about things that you never ought to have to worry about- you get to a situation which is strange in view of the fact that I've been so involved with people- where initially I would walk the other way if I saw somebody that I knew... no explanation whatsoever.

Martin also suggested that it was an experience which he was incapable of describing, even to his wife.

Martin: Well it's just - you can't because - I could never describe it to my wife, way I were feeling, you know.

He described depression in terms of the confusion he himself felt, as a strange feeling, unlike other experiences, and overwhelming:

Martin: It's just everything's mixed up - I used to call it scrambled eggs - your brain was scrambled - and it was just strange feeling - just can't explain it, what it were like.

2. Being taken over

Participants described depression as something which happened *to* them, which was overwhelming and which took them over. In Geraldine's, Martin's and Eric's accounts there was the implication that when depressed they were not able to control their behaviour and they were not themselves.

Geraldine, in response to a question about whether she had ever felt depressed, described depression as "it", as a thing which kept happening to her. Unlike the other participants, for whom depression was an ongoing problem, Geraldine suffered periodic bouts of depression. She contrasts depression to how she normally feels:

G'ine: It [feeling depressed] keeps coming and going. I feel shocking when, you know, just horrible, you know, just sitting there doing nothing.

Siân: Yes.

G'ine: I'll do a little job and sit down and then -. I don't know what's causing it.

She is "fed up" with herself when depressed, she feels terrible and she is unable to help herself or to lift herself out of it. The problem, as she identified it, is how she feels about herself. She is not aware of behaving differently. She also suggested that she might feel like this because of all the drugs she is taking.

Siân: Yes. What do you think about when you get depressed?

G'ine: I'm fed up with myself.

Siân: Yes. What, with yourself?

G'ine: Yes.

Siân: Are you fed up with anything else or - ?

G'ine: No. No. Just fed up with myself.

Siân: Yes. Do you behave differently as well?

G'ine: I don't behave differently. I just feel different.

Siân: Yes. You mean totally different to how you feel - ?

- G'ine: Yeah. Well, when I wake up in the morning I feel rubbish, then I have a teapot full of tea - three cups of tea in a morning! I can't bring myself round. I feel shocking. Maybe it's the tablets, you know. All those tablets.
- Siân: Yes. Does the tea help?
- G'ine: Yes it brings me round.

Similarly to Geraldine, Martin talked of depression as an "it", as something which happens to him, which confuses the mind and takes it over:

- Martin: I think it screws your mind up - just plays tricks with you - and does different things to you. I can't do anything you know. I've been - gone out to places to try and put my mind off it - when I were poorly. And the weirdest things have gone through my mind, you know. I've gone through an experience of being awake in the morning - but dreaming. And how you work that out, I don't know.

Martin has experienced a sense of total confusion and unreality, as if he were dreaming. He has been unable to explain this even to himself, and there is a sense of being cut off from the world around him:

- Martin: And the weirdest things have gone through my mind, you know. I've gone through an experience of being awake in the morning - but dreaming. And how you work that out, I don't know. I've been wide awake - but going through the weirdest dreams - so really mixed up. And then asked to explain them. I couldn't explain them because they were that mixed up, you know. Just laid awake you know - know I were awake - but just shut your eyes and you're dreaming - but you're awake.

The conceptualisation of depression as an "it" within Martin's and Geraldine's accounts has wider implications, since it serves to contain the problem and suggests that since depression is something which happens to them they are not responsible for it. Indeed, part of the problem for them is that they cannot control their feelings in depression. Since both had been receiving treatment as psychiatric patients over several years, their conceptualisations of the problem of depression may also be understood in terms of a received medical discourse which identified their problems as the distinct problem of depression.

Eric similarly experienced himself as out of control. A focus of the interview was his description of being subject to uncontrollable shaking (although this was not actually apparent in the interview). There was nothing he could do to control this. But he had no identifiable factor to blame. Throughout the interview there was a strong theme of self-blame and responsibility for the fact that he could not control his shaking in daily life, and this in turn contributed to his anxiety.

Eric's problems of anxiety were not new, but in contrast to the past he felt unable to cope with them. He could not enjoy things he used to enjoy, because he was unable to stop himself worrying:

Siân: Was it like this when you were a lot younger as well? Twenties or something?

Eric: Oh no. I've had it a long time but I was fit.

Eric: I like watching a bit of sport, like football, because I used to play a lot when I was young and that, running and that, but when something comes on, I get into it and all of a sudden, I think of things and I don't bother.

His was not a periodic or a sudden but an on-going, long-term experience of distress. Since he habitually shakes in company, he has no other experience of self against which to define this experience as different from his real or normal behaviour. Therefore it may be more difficult for him to specify or limit the problem as one for which he is not responsible. At the same time he felt that he had no control over his behaviour.

Eric: I can't pick up a cup without shaking. It's alright for the wife and lad and daughter but anybody else I just can't do it. I know some people can, it doesn't bother them, but it bothers me. It hits me straight away when they're looking at me and I'm worse.

Eric: I just can't converse and I just can't... People might think that we're mardy and miserable or something like that but...

Eric: I can't relax. I just can't relax. When I go to bed I'm laid there and thinking. As soon as I wake up, thinking

3. Not like I was? Loss of self

There was a strong theme of loss of self. This was experienced as loss of confidence and loss of the ability to act and participate in life. Participants suggested that since they had become depressed they experienced their everyday lives or themselves as having fundamentally changed. They no longer functioned as they used to. This was mysterious and inexplicable.

Douglas still thought of himself as the same person. He had no regrets about his past. But he was puzzled and mystified by how he felt in the present, which was inexplicable to him. In particular, he had no motivation to start the day and could find no reason for this. He saw this as a problem and a mystery in himself, rather than suggesting that the problem was that there was no reason for him to start the day.

Siân: Do you still feel the same person now...?

Doug: Yes... I feel the same person... I would do the things that I have done in the past, but I'm, er, you know, I don't want to get up in the morning... And if I've been thinking about something I'll probably have to force myself to get out of bed... ridiculous really... there's no reason why I shouldn't get out.

More specifically, the way Douglas behaved had changed. He avoided people, whereas in the past he had been highly involved in community and trade union work. This is something he cannot explain to other people nor to himself. He seems to have lost all confidence in himself.

Doug: You feel so low, dispirited and worry about things that you never ought to have to worry about... you get to a situation which is strange in view of the fact that I've been so involved with people... where initially I would walk the other way if I saw somebody that I knew... no explanation whatsoever.

Martin also described not wanting to face the day. He himself felt totally confused:

Martin: It were a struggle getting out of bed in the morning - I didn't want to get out - I didn't want to face day. And I were so mixed up in me head - these strange feelings in your head.

He has totally lost confidence, which makes it difficult to cope with daily life. He has lost any sense of himself as capable and confident. While this may be part of his experience of depression it also sets up a vicious circle, since it makes it difficult to act or to achieve anything. For him, part of the process of recovery is to gradually build up his confidence again.

Siân: Is it totally different then to how you were before all this started - do you feel the same person, or do you feel you've changed?

Martin: Yea. Because I haven't got confidence like I did before... I don't get gist of the story half the time - I lack confidence. I were a very confident person before - and I know that's gone.

Siân: Is there anything that does kind of help - that makes you feel a bit confident again?

Martin: When I've done something, you know - when I've achieved something like, you know - I feel great - elated like, you know. And gives me, boosts me confidence - till next time.

Siân: And then the next time?

Martin: It comes back, you know. Square One again - or maybe just a little bit better. And that's probably what's contributed to me getting better like. Because I didn't want to tackle anything - and wife says 'you've got to, you've got to do these things, you know, you've got to try'.

Chris also suggested that he no longer felt himself. He does not feel down or depressed in the conventional sense but feels that he is not how he was. There is again the idea of loss of self here.

- Chris: I don't know, but what affects me more is, you know, not being... I mean, it's not that I can't do anything it's just that I'm not like I was... It's that that I think of more than being miserable or fed-up and depressed, you know, this is what gets me more than feeling a bit down...
- Siân: Do you feel miserable and fed-up?
- Chris: Sometimes I do, I suppose everybody gets like that, don't they.

Part of the experience of depression is being unable to understand one's own behaviour. Frank experiences moods and behaviours which are different from his previous behaviour and to him totally inexplicable. He has become irritable, and can see no reason for this:

- Frank: Ooh aye. I get right snappy with wife - I've had her in tears, wife - and I love her a lot, and I love daughter a lot. But I've had wife in tears - I snap - I don't know what I snap at.

4. "I can't cope with life"

Participants described feeling unable to cope with daily life. This was combined with feelings of stress and fear and anxiety. Martin, for example, defined depression in terms of being unable to deal with the everyday difficulties of life.

- Martin: I can't cope with life - that's what it boils down to. You know, everyday knocks of life - it knocks me back. That's what depression is - as I define depression.

Both Douglas and Eric suggested that they had always worried a lot, but the problem now was that they were unable to cope with their anxiety. Douglas explained that he was continually worried, beyond what could be justified. He condemns himself for it but is unable to control it. He is overwhelmed with worry.

- Doug: I've been a worrier but not in the state that I'm in now . As I say, I make mountains out of molehills, stupid little things you know.

Eric saw his problems as building up when problems built up at home and he felt compelled to worry.

- Eric: It builds up when things get worse at home. I think a lot. I worry. The least little thing, my wife will say don't bother about that, and I say I've got to.

Martin suggested that depression is an experience of fear and anxiety. He saw it in the faces of other patients in the out-patients' department:

Martin: I've seen people in here - you can spot them - because I've spotted one or two that are poorly like you know - you can see in their face. And I says to wife 'were I like that?'. And she says 'yeah, you know, you were lost, like, scared'. It shows in your face.

Part of the problem is that people are unable to control or account for their experiences. A constant source of anxiety is the fear of appearing different. Thus for Eric a problem is that he is frequently prone to uncontrollable shaking and becomes self-conscious and fearful of other people's reactions to this. He withdraws and avoids meeting people:

Eric: When wife's here, as I was saying, family, so it's accepted, they don't look at me and they don't see this and I don't... And it doesn't bother me, but anybody else I start sweating and I've thought what's going to happen here and thinking-.

Eric: If it was the other way round I'd think, 'why he's shaking a lot, but I'm not saying anything', but people just don't think, do they? They just come straight out with it, 'what are you shaking for', and they shouldn't do it... ninety per cent it doesn't bother... But such as me... I'm always getting hidden, in corners.

5. Summary

Depression is identified as a distinct problem and as an entity, something which happens to the person. But the experience of depression may also be understood as a changed experience of self, where the change of experience is sudden and dramatic. It may be interpreted as a loss of self. It includes a feeling that one is unable to cope with daily life. This includes a sense of difference from others (as also noted in Study I, Chapter Two), where the individual feels deficient in relation to others. Depression is also feeling powerless and frustrated. Individuals feel unable to cope and cannot explain why they are depressed nor what is happening. They are at a loss in terms of coping with their daily experiences and feel unable to control themselves or to change their situations.

PART C : EXPLAINING DEPRESSION: EXPLANATORY FRAMEWORKS

This section will look at how participants attempted to make sense of or to explain their experiences of depression. As has been shown, one problem in experiencing depression is the difficulty of explaining or describing how one feels in an attempt to get some sympathy, recognition, and understanding. Secondly, participants suggested throughout their accounts that they needed to be able to account for depression by giving a reason why they were depressed. The need to be able to account for depression in terms of giving a causative reason might serve to justify how they felt and make it more comprehensible to others. But it was also important in their own attempts to make sense of depression, to make it comprehensible to themselves, and to set a boundary on it.

The notion of an explanatory framework is developed from Karp's (1994) work on the careers and identities of patients diagnosed as depressed. He identified a process whereby individuals explained their problems in terms of their situations but, when problems continued, began to see them in terms of a problem in the self and to see themselves as depressed.

1. Depression is a mystery: there is no reason for it

As has been discussed earlier, there is no way of accounting for or explaining the problem of depression to oneself or others. Douglas suggests that if there was a reason then it might become more easily acceptable and comprehensible to other people.

Doug: They can't understand why you do it. If there was an explanation for it I suppose that would be... make a difference, but... can't explain it at all.

2. Explanatory frameworks: Situations

2.1 Specific causes: unemployment, loss and lifestyle

Unemployment was identified as a major problem by out-patients in their accounts. (Here the term unemployment is used to include the loss of work through retirement, as for Douglas). Although it is not clear that participants see unemployment as a definite cause of depression, as for example in the accounts of Chris and Douglas, for whom depression is still a mystery, there is an implication that being out of work is at least part of the problem. Frank, on the other hand, sees his depression as caused by unemployment and was clear that if he was employed he would recover.

Unemployment is significant as a loss of role and identity and as a loss of control and power to make positive choices within one's own life. One problem here is that

individuals were powerless to effect a recovery. They were powerless both in being unemployed and depressed.

Frank suggests that he cannot pull himself out of depression and that he is dependent on having a job:

Frank: They said to me "It's up to you to pull out now" - I say "I can't". I said "If I got a job tomorrow - this'd all go, in a week or a fortnight - it'd go, it'd go".

Giving up work through retirement or being made redundant is an experience of loss and may be experienced as a sense of powerlessness. Douglas had become depressed since he retired. He had been heavily involved in community and trade union work and as a J.P. until retirement. He saw his problem as not having enough to do and he feels powerless to find more to do. The problem had arisen since he had retired, although he did not necessarily see his retirement as the cause of his depression. Implicit in his account is the idea that, for him, retirement has been an experience of loss and powerlessness. Adjustment to loss is a process of trying to rebuild meaning through new relationships which re-establish some of the meaning lost (Marris, 1974). But Douglas feels powerless to find new activities and re-establish some purpose in his life.

Doug: It's since I finished work that I've got, sort of like I am, you know, depressed and that. Mainly because I don't, can't occupy my mind, I can't concentrate like I used to...I don't remember things.

Doug: I don't have enough to do, quite frankly. Quite honestly, I don't know what I can do to find something to do.

The loss of work may be experienced as a loss of self (Oatley and Bolton, 1985). What is at issue is not the loss of a job alone but the impact of this on lifestyle and sense of self. Douglas lost his sense of involvement in community activity and seems to have lost any sense of self-worth. The loss of work has real economic and financial implications which limit all activity. For example, Frank is unable to participate in his old habits, to go for a drink or to work on his hobby of restoring cars. For Frank, the problem of unemployment led to the loss of important leisure activities which were important sources of pleasure and self-esteem. The implications for individuals of unemployment are powerlessness in psychological, social and economic terms.¹

¹ Oatley and Bolton's (1985) analysis of loss through unemployment neglects to look at real financial and economic implications of unemployment, since it conceptualises the problem in abstract cognitive terms which ignore the social and economic consequences of unemployment in individuals' everyday experiences.

Frank: If I had a job - any job. I'd do sweeping up, I'd do sweeping up, picking paper up - owt. And I think in a fortnight it'd go. I'd be back to my old self again - getting a little bit of wage - a little bit of money in me pocket - a little bit of money to go and get some presents at Christmas, you know what I mean. I've got owt, owt, nothing - I get my bacca - Jan [his wife] sees to me 'bacca - and that's about it. And when I pass boozers and that - as I've told you before - and I'd see them outside - having a laugh and a drink. I feel right down again - you know what I mean - right down. And when I see all these latest cars that's come out now... Showrooms - you know like Y Road, X's - 'can I help you, sir?' He comes to me 'can I help you sir?' - I say, 'not at these prices, me old love - them days is gone for me like'.

Siân: Do you feel less self-respect?

Frank: In a way, in a way. I've never had no - never been very clever - only with cars.

Siân: Is it one of the things you're good at, you can't do now?

Frank: No, I've never been clever reckoning up here and reckoning up there - I get by. But that were my love that, the cars, ooh aye. When I were working I used to go to car sprays, and buy all these stop-lights. Everything was to jazz it up, do you know what I mean. And when I used to light up, I used to have a crowd round me - and it were good, it felt good.

The experience of depression and of unemployment may lead to the construction of the self as a failure. It is not only a loss of self, but is linked to the experience of powerlessness, the powerlessness to change one's situation by having a job, and the powerlessness of feeling depressed and so feeling unable to help oneself. For example, for Frank:

Frank: And then I've been in bed, and I've took "Reporter" [local paper]- and I just burst out - failure, do you know what I mean - failure. An' the wife's come in - I didn't want to do it in front of them - but she's come in. And I've been laid in bed and ruing it - I've told her I'm a failure and this and that - and she says 'Well, that's it, you'll have to sort of come out of it'. And I've tried and tried and I can't. I've got no money in my pocket, got no money at all.

Frank blames himself and feels responsible to some extent for his problems, at the same time as he now feels powerless to help himself:

Frank: Never saved any money. No, there were my big downfall that. And as they all say - they never saw it coming.

Siân: You can't blame yourself for that.

Frank: Well I do, well I do.

Given that the problem of depression may be seen by sufferers as caused by unemployment, then the psychiatric and medical care offered may be seen as

inappropriate. (Doctors themselves may also see the problem in social rather than medical terms (see Chapter Six, Study III)). Chris saw consultations at the hospital psychiatric out-patients' department as achieving nothing, and the solution to his ill-health as regaining employment. This was based on his G.P.'s analysis of the problem. Individuals could be seen as caught in a trap of irresolvable circumstances; they felt a job would be a solution to their problems and yet felt unable to get a job given the poor state of their present health.

Chris: I come out [of the psychiatric out-patient department] and I think, "Why have I just been here? you know, nothing's changed or anything". It really seems to be like a vicious circle... Well, I've got a bit of a theory, same as my G.P., he keeps saying, "If you were in work, earning money again, you would like snap out of it ". But, you know, as I am now I couldn't work.

2.2 Illness as a reaction to stress

The concept of illness was used in suggesting that depression is a reaction to stress. However, illness was not necessarily understood within a disease model, in terms of individual pathology. Here, the individual may still consider their situation as the cause of the problem of depression.

The notion of illness can be seen as validating problems as serious and real. It also defines the problem of depression, and defines it as something the individual has rather than is. Thus, although an illness, depression can be explained in terms of the individual's situation.

The label of illness, when explained with reference to a specific cause or a situation such as unemployment, need not necessarily be seen as pathologising. Although depression is experienced as a real problem within oneself, the cause is located outside oneself. Thus, the seriousness of the experience can be validated with the label of illness which does not necessarily have pathological connotations of personal deficiency or weakness.

This is shown in extracts from the interview with Frank. He considered unemployment a reason for his anxiety and depression, which he understood as illness.

Frank: But anxiety I think it's an illness now. And I says to the doctor, 'How long will it be before I get back to normal?'. He said, 'I just can't - it's up to you - to come out'. I said, 'I know it is in a way'. It always comes back to this question - a job. We always finish up - I'm out of work - and I haven't got no money in my pocket. That's what we come back to.

The positioning between two alternative conceptualisations of the problem of depression, as a medical illness and as socially caused through unemployment, is, however, potentially contradictory and may leave the individual feeling powerless since there is no medical cure available and the individual is unable to change his situation. Although the experience is seen as an illness there is no medical cure. Frank's G.P. had suggested that the solution lay with him. But the problem is then irresolvable since the solution, which he understands as employment, is not necessarily attainable and is beyond his control. He is placed in a contradictory position between being told the solution lies with himself and being unable to provide a solution.

Frank believes the problems he is experiencing are common and are caused by unemployment. There is no indication that he sees himself as pathological in being depressed. His chief concern is that he does not have a job.

Frank: I don't know what anxiety's all about - and stress - really. You hear lots about it now. There's a hell of a lot of people with it now - being out of work. It's unbelievable what people with anxiety now - and stress. And people won't come here for treatment - you know what I mean - for treatment or whatever. I couldn't believe it - it's coming up a lot now - this anxiety and-. It's people out of work and that's it. And I think it boils down - I haven't got a job.

Siân: This panic, do you think it's a kind of illness?

Frank: It'll be illness I think - I think it's an illness myself.

Siân: It's not just what's happened in life?

Frank: Naow, it's bloody illness I think - what I've got now, I do. But I don't know much about anxiety. People what's got different opinions than what I'm saying, I don't know. They might have got a rough background, something like that - with husbands always hitting them and all like that. My problem is - I haven't got a job.

3. "There's something wrong with me"

Problems were also seen as long-term and as transcending the situation. Individuals might then see themselves as the problem and believe that something was really wrong with them. This provides an alternative conceptualisation to that of illness as a reaction to the situation, since the problem is seen as located in the person.

The belief that there was something wrong with the person might also carry with it a sense of hopelessness about the possibility of recovery, and the inevitability of relapse. For example, Martin is completely puzzled by his experiences of depression, and accounts for them in biochemical terms as clinical depression and as pathology. He sees the problem as located in his biological make-up. But this means it is a problem that is always threatening, and since there is no apparent reason for his initial attack he lives in

fear of a relapse. He sees his appointments at psychiatric out-patients' in terms of management and control.

Siân: So has there been much help for you here?

Martin: Yes. I see this as a safety net. If I do start getting bad again - I'll see to it. Because what did happen to me the first time - I were just discharged from hospital - and forgot about.

Eric, who conceptualised his experiences in terms of his "nerves", also has no hope of resolving them but sees them as inevitable:

Eric: I'll never get rid of nerves. I'll never get rid of what I've got. I'm getting worse I think because I've got a lot of problems.

He believes that his problems with his nerves are aggravated by problems at home, but also suggests that it is a weakness in him that he is unable to control his anxiety:

Eric: It builds up when things get worse at home. I think a lot. I worry. The least little thing my wife will say don't bother about that, and I say I've got to.

In identifying his problem as his nerves he can also be understood as attempting to distinguish his problems from himself. He suggests that he would be alright if it was not for his nerves. The identification of problems as "nerves" can be seen as functioning in the same way as the identification of illness. However, it is not necessarily successful.

Eric: I might be round the blooming bend in some ways but if it weren't for nerves I'd be alright. I don't do daft things, don't get me wrong. I don't do daft things. But it's just facing up.

He explains his problems in two ways: as his nerves, and difficulties in the situations of himself and his family. He is concerned about his wife and son but sees himself as unable to help them. The problem of his nerves is irresolvable and he appears to have given up on himself. Although he says that he can cope, he is also hopeless as to the possibility of resolving the problem of his "nerves". He appears resigned to the idea that no help is available for him.

Eric: If everything went smooth. I'm not bothered about my complaints. It's my wife's and lads. You know if I keep out of the way, I can cope in my own way. In my way, but it gets me down, it's no good to nowt, but if wife's alright or something like that... It seems a dead end now. Just a dead end.

Eric: If lad were alright and wife were 100%. It wouldn't make no difference to me I don't think, not now.

His conceptualisation of his problems as something wrong with him, as his “nerves”, leaves him powerless. The idea that there is something wrong with him means that he sees himself as less than able to cope with problems: it is his fault that he becomes worried and this is not justified by the problems he faces. This is similar to Douglas:

Doug: I’ve been a worrier but not in the state that I’m in now. As I say, I make mountains out of molehills... stupid little things, you know.

Here the individual sees their self as the problem.

4. Summary

Explanatory frameworks for depression identified here suggest that depression may be explained in terms of a person’s situation, and that the alternative form of conceptualisation is in terms of a problem with the self. People may see the problem of depression as a problem of self when an explanation in terms of their situation fails to explain why they are depressed or is not available. Conceptualisation of depression as an illness is also linked to seeing the problem as a problem of oneself, but as an illness it may also be seen as a reaction to a stressful situation.

A distinction should also be drawn between the notion of an explanatory framework and that of causation. Individuals may *explain* their experiences of depression in terms of a difficult situation, or see depression as a problem with the self, but this does not necessarily imply that they see either their situation or their self as the *cause* of depression. However, the explanatory framework also has implications for self and identity: if depression is seen as a problem of self, then the individual can be seen as adopting an identity of self as depressed. Seeing the problem in terms of the situation may be a means of avoiding any implication of a deficient or pathological self.

PART III: RESULTS: PATIENTS OF GENERAL PRACTITIONERS

As discussed earlier (Chapter Five, Part I, Section 6), the data for the patients of general practitioners were analysed on a within-interview or case study basis, and here are presented on that basis in order to demonstrate the variability of accounts and convey a coherent analysis of themes used *within* accounts.

Data analyses are presented from interviews with three participants: Angie, John, and Pat.

INTERVIEW 1: ANGIE

Introduction

Angie was in her early thirties, had recently married and had a young baby. She had previously worked full-time as a self-employed, dental hygienist, work which she had given up to look after her child. The week of the interview she returned to part-time work, two afternoons a week. Her husband worked in finance, and they were comfortably off, with a home in a pleasant city suburb. For both it was their first marriage and their first child.

Angie was very welcoming, and very open during the interview. She came over as a very friendly and out-going personality. She also gave the impression of someone who was active and liked to get on with things.

Angie explained that the immediate focus of her problems was a wind chime in her next door neighbour's garden. This was a constant irritation since it was rarely silent, which had reached the point where she was unwilling to go into the garden or the back of her house and felt confined to the front rooms. She and her husband were planning to move, and had already found another house. However, she was aware that there were other problems, including the loss of her financial independence and her traumatic experience of childbirth. She believed that the move would give her the opportunity to make a new start in her life with her husband.

She had felt depressed during her pregnancy, and was annoyed that she had been dismissed as a pregnant woman and was not taken seriously then or subsequently, despite attempting to talk to her G.P. and health visitor before and after the birth. She had not been diagnosed as depressed until she scored highly for depression in a post natal survey (not specifically about depression). She was attending the general practice counsellor, and her G.P. was also arranging for her to see a clinical psychologist. She

was also on anti-depressants, which she said had the general effect of dulling her down rather than actually solving the problem of depression. She took a psychological and counselling based view of depression, as something for which the causes might lie back in her childhood

Analysis

1. Relationship

1.1 The loss of income and responsibility

Angie explained her experiences of depression in terms of her situation and specifically through the loss, of independence and autonomy, which she experienced in motherhood.

Angie: Yeah, well really I think what it started with initially is I was pregnant and I had a difficult delivery etcetera, and I found a lot of the problems started after I'd left work. I left in May and the baby was born in the September so I had quite a break... So I found that I felt I wasn't contributing financially to the household, and I felt as though I was living off my husband, which is stupid because we hadn't been married very long, and I've been working since I was 21 and so I'm used to going my own way.

This excerpt contextualises Angie's problems within recent changes in her life, most notably giving up work. She identifies the loss of work rather than her child as a source of problems. (Throughout the interview she appeared happy with the baby.) It was not the baby but the loss of independence and autonomy which she experienced as a problem.

She reflexively constructs herself in terms of the situation, aware that the situation is a problem but also implying that she misinterpreted the situation. Her account focuses on how she feels about herself in the situation, and is not restricted to seeing the situation in itself as problematic. For example, she comments that it is "stupid" to feel as if she is living off her husband. She is financially dependent on her husband, she considers that she is contributing nothing to the household, and sees herself as worthless. She believes this is a problem in herself, and implies that she cannot justify her feelings.

She is trapped in a contradiction, since she both feels that she is a burden and that she has no right to feel like this. At the same time as she has no rights to feel like this, she also feels that she has no rights to, and cannot justify, her expenditure. There is a contradiction within the account since she seeks to construct her husband as blameless and at the same time suggests that, although he has never openly accused her, he does in fact control and possibly resent her expenditure. She explains the problem through reference to herself and her husband in these two contradictory approaches.

Angie: But you see, I feel now that I can't make a claim on, saying, 'can we have this? Can we have that?' Because I'm not earning, up 'til Monday I wasn't earning any money. You know, and he's not tight, he's not like that, he'll say have what you want, but I feel I can't justify it... So I don't resent that, you know I feel I've got to be more careful with money because the salary's been cut by one. But I just feel that I'm a drain on him. You know, and he's never indicated that I am, but he's been alone for a long time and he's not been used to having a joint relationship and everything, so I think he finds it hard to part with his money.

1.2 Loss of autonomy and identity

Angie is aware that having the sole responsibility for full-time childcare is a problem for her, but again she is caught in a contradiction. She constructs her husband as justified in terms of his work and at the same time she is clearly very angry. She feels guilty at criticising him and simply expressing the problems she is left with. She resolves the contradiction by seeing herself as the problem, because she is unable to cope, and her husband as faultless. At the same time she is aware that she has lost what he still has, a life outside the home, a sense of autonomy, and individuality, and that she is now restricted to her life in the home and as a mother. She is clearly angry about and resents this, but cannot justify her anger to herself. Her account suggests that she is aware that the situation is very difficult and that she is powerless to change it.

Angie: And I go hysterical, I go mad at him when he gets in late, because I've had to do the total baby-care all day and it's not his fault, he doesn't like it, he can't like working 14 hour days. And so I have a go at him when he comes in and then I feel guilty for having a go at him, but again I feel, "He's got his job, he's got his separate life, I'm stuck here."

It is notable that while Angie recognises and values her husband's work it is not clear that her work in the home is recognised. She is caught in a contradiction, both resenting her position and feeling that she has no right to complain.

Angie has experienced real loss within the relationship, and through motherhood. Whereas she believes that the loss of time for herself is an inevitable part of having children, she sees the real problem as her loss of her individuality, not just through motherhood but also through marriage. This is symbolised for her by the fact that she moved into her husband's house, as well as now being dependant on his income. There is an implication that their relationship is structured on his terms not hers, and that it is his life which has continuity within the relationship, it is hers which has changed and she is the one who has lost. They plan to move locally, and the new house represents the chance to establish a new, more balanced relationship.

Angie: Whereas now I don't seem to get any time to myself. Which again goes with having children really. But I do feel that a new house would be a new start, that we've chosen together, and we can do it from scratch, and we won't be left with the carpets etc. that the previous people have left. You know, so you can put your individuality on it.

Her resentment of motherhood is focused on her husband rather than the baby. She has lost her independence and freedom. Through motherhood and the circumstances she has experienced it in, she has experienced a great loss of herself and her identity. She cannot be satisfied by motherhood alone and the circumstances, especially loss of her own job, have rendered her dependent and powerless in her relationship with her husband, at least temporarily. This is emphasised in the excerpt above: the ownership is her husband's since she is stuck in his house, with his baby, and she has lost the things which she feels were her own, her job and her income. She has lost what she felt defined her as an individual and she now experiences her life in relation to things which are her husband's.

Angie: And I just felt, at the end of the day it was down to me; he needed breast feeding every two hours, and again you feel that you've got no time to yourself, which has passed now because he's a lot easier, but I feel that the house is like a prison, that I'm stuck in this house, which is my husband's house, and I'm stuck in with his baby, and I've given up my job, my income, because of him.

1.3 Construction of Angie as the problem (by her husband).

Although Angie has indicated that there are problems in her relationship with her husband, she locates these problems within herself, constructing herself as unreasonable and irritable. She herself becomes the problem within the relationship, and is rendered powerless within it. But it is also implied that her husband constructs her as defective and as the problem.

This is most strongly pointed out when she suggests that her husband is the norm she is measured against. He has a calm manner, she is given to unjustified reactions and is at fault. She is angry at her husband, in particular for his failure to react or to respond. But she also appears to accept that she herself is the problem, as he sees her.

The contradiction is again present between her account of her husband as blameless and her anger with his behaviour and his attitudes. She can be seen to react to him in contradictory ways. Spontaneously, she is annoyed and frustrated with him and implies that he should not be so calm and non-reactive about life. Her account may also suggest that she did not feel listened to by him, and that he did not accept that real problems

existed. But while she spontaneously became annoyed and criticised him, on reflection she decided that he was right and she was wrong.

Angie: And so I just thought, I am snappy, I am intolerant, and my husband would make out, he's very easy-going, you know, and he'd feel- 'Why can't you be more like me,' he'd say, and so I'd say, 'God, you're like Pollyanna,' You know, from Sunnyside Farm, you know, I said, 'Get mad,' like that, and he just won't, and I thought well, you're the same birth sign as me so it must be me that's wrong, and he said, 'Go and get help,'

He is seen as behaving correctly according, to their birth sign, and she as at fault. There is an implication that she is being judged against some established norm, in her reference to birth signs. Angie said several times during the interview that she had always been short-tempered and irritable, in a self-critical assessment which ignored any reasons she had. Her husband also believes she is at fault and needs help, that she is deficient or pathological in some way.

Within her account, her husband appears to construct her as the problem. She suggests that he believes that a change of behaviour, if not of personality, is needed, that he sees her as the cause of problems. Through comparison to his own non-reactive and therefore apparently non-problematic personality as the norm, her husband succeeds in pathologising her. She herself does not refute this, and again she does not criticise her husband for his behaviour, instead accepting what he says and constructing herself as at fault while he remains blameless.

Angie: But because he is easy going, it does diffuse the situation, but on the other hand it can get to the situation where I feel, 'Oh for God's sake react,' and he felt by me having treatment, that they would make my personality more like his, and I said, 'Well you can't,' 'cause it just shows peoples attitudes doesn't it? I said, 'Geoff, short of a pre-frontal lobotomy there's nothing I can,' you know, I said, 'They can't.'

She has accepted that she herself is the problem. She anticipates a personality change when they move house, and implies that she needs to change. This may distract her from confronting problems in their relationship, since problems are constructed only in terms of herself or specific factors in their situation. She implies that a lot of the problems are to do with the house she is living in, but also that she herself is the problem and it is her reactions which are unreasonable and problematic. Consistent with her suggestion that she has lost her individuality and autonomy, she here suggests that problems will be resolved by a change of surroundings, in a choice of home that is theirs rather than his.

Angie: As I say, once we've moved we're nearer parks and I feel like it's a fresh start and so I can present a new self, it's almost as though I'm going to have a character change, and I can feel that I will be happy in the surroundings and therefore be more confident to go out more and do more.

It can be seen that Angie's experiences of herself as problematic are largely linked to her experiences within her marriage, where she has been constructed as problematic and potentially defective. While she links her unhappiness to her loss of her independence, freedom and autonomy, she does not, however, see her relationship as a cause of her problems. Thus, although she recognises difficulties in her marriage, she implies that has no right to experience difficulties. The denial of her rights is also linked to her loss of financial independence, and her position of dependence on her husband. This is both a cause of her problems and means that she has no right to experience problems. She locates her problems in herself, in her personality, as pathological. She is anticipating an improvement through her change of circumstances, but still sees her personality as at fault.

2. Experience of motherhood.

2.1 Feelings of inadequacy

Angie: When did this paranoia start? No, I find how it manifested is that the delivery, as I say, was very difficult because it was... a forcep delivery and it was a very big baby and it broke my coccyx and so I couldn't move, my mobility was very limited, I didn't hate the baby at all, but I just found I felt cheated because I was down for a G.P. unit, and ended up being consulting care. And so I felt that I'd failed again there, but it was an eleven pound baby, so it was hard.

Despite that fact that she feels cheated by the medical staff, who had noted the size of the baby but not acted, she also feels that she has failed as a mother, because she was unable to have a natural birth. So while she feels that she was let down, this does not prevent her feeling that she herself has failed.

She felt she was inadequate when she faced difficulties, for example in breast feeding:

Angie: He was naughty to start with, and he wouldn't - not naughty, sorry, he just wasn't very happy and he wouldn't feed properly, and all the other mothers were managing to breast feed and I did breast feed him but I had to do it every two hours

2.2 Loss of respect, powerlessness

The delivery established her identity as a mother, in terms which merely saw her as a body. During the delivery and after care she felt devalued. So her new identity as a mother was initially constructed through experiences where her own validity and

person where denied. The loss of identity and self-worth, which she has experienced in her relationship with her husband, was also experienced in her medical treatment. She has lost her own identity in motherhood, and feels devalued and abused.

Angie: I was left to go for 23 hours and it was very, very - I was out of control. I was transferred over to consultant care, and you just get somebody in every hour just to check you... they just come in and check your cervix. It's just a job to them, but I just felt - I said, 'Look, what's going on? Can you tell me what you're doing with me please?' 'Cause I want to know ... any procedure carried out, I think with the nature of my work, I like to know what's happening, and they wouldn't tell me, you're just left to go. And I thought, 'If I was a horse you would have shot me by now.' It wasn't what I wanted it to be.

Angie: They'll say, "How's Mother?" And I hate that. You know, you think, "I have got a name".

2.3 The social construction of motherhood and structural problems

Angie is disappointed in her experience of motherhood. Although the notion of post-natal depression is available to her as an explanation and she does attribute her problems to it, she does not believe that it is the full explanation. She identifies difficulties in the social structure of motherhood and parenting where the full-time demands fall on the mother alone. She is disappointed in her experience of motherhood, but believes that this is due to the lack of support, for which she does not blame her husband but the system of parental leave. The mother is left to take the full burden of care. The experience of motherhood has changed Angie's self-image, she now feels as if she is seen simply as a body, servicing her child full-time.

Angie: But post-natal depression actually has played a part in it though, that's made it worse, and he was naughty to start with, and he wouldn't - not naughty, sorry, he just wasn't very happy and he wouldn't feed properly, and all the other mothers were managing to breast feed and I did breast feed him but I had to do it every two hours, and I just felt like - to be an exhibit at Chishurst show, you just feel like mooing, and going round with your shirt undone all the time, and people don't tell you what to expect with your first. First baby, the books make out it's all wonderful and it's not, it's horrible. We never once thought, 'Oh my God, what have we done,' but I just felt I could have done with some more support, like the Swedish system is, the mother gets six months off, then the father does, whereas here my husband had four days off, and that's all they would let you take off.

3. The diagnosis

3.1 Liberating

The diagnosis is critical in validating Angie's experiences of depression as a real and a legitimate problem. The diagnosis, by validating the problem, serves to distance it from herself, since because it is a real problem she no longer feels crazy or out of control. By distinguishing the problem as depression, she also believes that it is no longer seen as hormonally driven. Previously, when she talked to her G.P. about how she was feeling, it was dismissed as part of her pregnancy. She was thereby reduced to a "hormonal, crazy woman" (her words, below). Now that the problem is validated as real, she feels that she is being taken seriously as a person and not just dismissed as her hormones.

- Siân: You know when you said you were shocked when they said it was depression, did you mean, like, shocked, you thought, 'How awful'?
- Angie: No surprised, very, very surprised, and then - surprised then relief, I didn't think, 'Oh my God, I can't be depressed,' I thought, 'God yeah, that would explain a whole gamut of emotion, and I'm not just down in some post-pregnant, hormonal, crazy woman, or pre-pregnancy.' So I just - and I got a bit of patronisation initially, you know, when I was first - when I was pregnant it was, 'you're pregnant.'

The diagnosis is potentially liberating. It identifies and categorises the problem, and removes it from a discourse of personal, moral responsibility. Once the problem was validated she felt enabled to act, and she refers below to her and her husband's decision to move house. The diagnosis also gives her hope that the problem can be treated, and this in itself is a relief.

- Angie: The sense of relief, that I knew I wasn't going round the bend and that I wouldn't have to put up with this forever, and also the fact that it spurred us into taking some action about getting away from it, that's positive... It never occurred to me that I could be depressed, I just thought that I was a nasty person.

The medical validation of the problem as depression pathologises Angie since it is identified as an illness and as a problem located in her. It is also a relief because she then knows that she is not going crazy. It also suggests that the problem is not her personality. Thus the diagnosis both pathologises her and, in identifying the problem, distances it from her. It may be that the identification of the problem limits it. The problem may be located in her but it is not she herself who is the problem.

- Angie: My husband initially believed, "Keep your chin out, pull your socks up", and didn't realise anything was wrong, so I felt that it was just me that was just being like this, so I feel that now I've got a label for it, it makes me feel better because I can compartmentalise it a little bit more.

The diagnosis provides an escape from the idea that she is weak or morally at fault, as implied by her husband when he tells her to "pull her socks up". Thus, although pathologising, the diagnosis is potentially liberating for her in terms of her relationship with her husband, since it suggests that she is capable of having real problems.

3.2 Stigmatisation

The pathological discourse also functions to portray Angie as defective, though in scientific rather than moral terms. Her problem is now constructed in more precise terms since it is given the label of depression, which gives her the hope that it can be cured, but this label pathologises her. The identification of her problem as "depression", in terms which locate it in her as an individual, although in some ways, as suggested above, limiting it and so distancing it from her, also pathologises her and this is incorporated into her sense of self.

Angie believes that friends regard her differently once they know the diagnosis, as potentially or possibly crazy. The identification of the problem as depression in medical terms, although it might have helped her by validating it, clearly has damaging implications for self-identity and her social identity.

Angie: At first my husband didn't want me to tell them, because again people's attitude towards depression, you must have come across this, it's such a social stigma attached to it... But they still thought, 'Oh God, she's going to start barking at the moon or something,' but I make a joke of it now, if I say, 'Can I come round?' if a friend phones, I'll say, 'It's OK, I've had my medication.' And they just find it funny. The husbands have been good as well, because they're real 'won't talk about emotions or anything' that lot, typical bloody rugby lot, they're just all, on the surface. And they've been quite good with me, they've not patronised me.

Angie copes with the stigma by accepting it. She is unable to reject the pathological implications of the diagnosis, and instead resists them more covertly by joking about them. The diagnosis of depression is a part of her social identity which she feels she has to accept, and which she hopes will be acceptable to her friends. It is through joking that she tries to make it acceptable.

She also reacts against the stigma and hopes to reconstruct understandings of depression, as an acceptable problem. She argues that depression does not have to be explained through biology. It is a valid problem which should be acceptable in itself.

Angie: She [counsellor] said, "It's just depression. Why have you got to give it a label?" And it's true, why should it have a label? I think it's just people who are - if somebody was ashamed of having it in my circumstances,

they would say, "Oh it's the baby that's done it", you know? And they would label it post natal. I think it's like people putting down pre-menstrual for shop lifting offences and things like that... They want a tag for it, to make it sound socially acceptable, whereas I disagree with that because I think it'll help other people, you know, to say, "OK, it's not such a bad thing", you know?

She emphasised that she believes that the problems are circumstantial and that identifying them as hormonal, or as just due to the baby, was an attempt to hide them. However, here again she shows that she sees them as a problem in her and that she herself, as the person who has "depression", is problematic. She is implying that she has to accept herself as problematic and that she cannot escape through a label. Thus, despite her identification of very difficult circumstances, she still sees herself as the problem.

3.3 Pathologisation

The price of validation within the medical discourse is pathologisation. Angie has been identified as someone who "has depression". She is left doubting if she can ever fully recover, or whether she will always be vulnerable to depression. The problem of depression is clearly located in her.

Angie: No, generally in my outlook I feel I'm going to get better. I'm worried that it might be underlying. You know, it might be there all the time. You know, I feel because I've had it so badly I can't see how you can get rid of it completely. It's not like having, I don't know, a cyst or something that will go. But I think, well, if I have something unfortunate happen in the future, say, like the first thing probably would be a bereavement of one of my parents, would that throw me back into a depression or would I be better to cope with it?... I don't know, um, possibly it could be in my nature to always be a little bit down - you know, I'm a bit upper down -.

Angie sees herself as personally weak, since she has suffered from depression and in particular because she now believes that she is dependent on medication. This indicates that while the diagnosis has identified and validated the problem in objective medical terms, it does not remove her sense of her own responsibility for it. She feels weak because she was unable to cope without medication. Depression itself is not the problem, so much as her weakness in being unable to cope with it. The alternative approach was to cope through talking to friends and family. She feels that it is a problem in her (rather than in them) that she was unable to do so.

Angie: I'm sad as well because by having to go on medication you're admitting defeat, that I've not been strong enough to talk about it, well, I can talk about it, I've not been strong enough to gain strength and help and a cure as such from friends and parents. Because I am an open person, I don't

bottle things up, I let it out, and I feel that I could have had a network of friends and family, they could have cured me, 'cause they've tried. So they feel let down and I feel I've let them down.

4. Summary

Angie accounted for her experiences of depression in terms of problems in her relationship with her husband, and in her experiences of full-time motherhood. These have been identified as loss of autonomy and of her sense of her own individuality within her marriage, which increased after the birth of their child when she lost her income and experienced herself as dependent on her husband.

She effectively loses her sense of herself in her relationship with her husband and through her experience as a mother. Within their relationship, her husband constructs her as the problem. These themes are developed more fully in interviews with mothers about their experiences of depression (see Study IV, Chapter Seven). Angie constructs herself rather than her partner as the problem, and in doing so both draws on his construction of her as the problem and avoids explicitly questioning him, or his behaviour, or questioning their relationship.

The diagnosis of depression is powerful, both in providing recognition and legitimation of her problems and in placing the problem, as depression, within her. It is liberating because in naming the problem it contains it, consistent with the results of interviews with out-patients (see Part II, above). Ultimately, it is stigmatising and pathologising because a problem which is located in her identifies her as the problem.

It is questionable how valid the medical diagnosis is, and how meaningful, given the problems she is experiencing in her relationship with her husband. While the diagnosis is a relief to her because it identifies a real problem, and releases her from her husband's reproach that there is nothing really wrong with her, it confirms the location of that problem in herself and ultimately pathologises her.

INTERVIEW 2: JOHN

Introduction

John was in his fifties. He was married and was involved in the care of his wife's children. He had been an art student but since graduation his work life had been made difficult by mental health problems. He had extensive experience of mental health services as a patient for over twenty years. He was interviewed as a general practice patient but at the time of the interview he was also a psychiatric out-patient.

He was very reflective and insightful, and gave the impression of a thoughtful person. This was seen in his interview where he gave a reflective account of his long history of mental health problems, relating them to self-development and personal growth, which provided an insightful approach to depression as an experience and development of self.

Analysis

1. The diagnosis

1.1 Identity as depressed.

John described himself as depressed, although he showed some ambivalence towards the label, because for him depression was not a constant state.

- Siân: Would you say you were depressed?
 John: I probably still am, I would say, yeah.
 Siân: Yeah.
 John: I mean, it's not exactly very obvious, I'd not say that I always feel depressed, I'm sure I'll get more of this coming out in the course of this session.
 Siân: So -. 'Cause, what would you - how would you say you've been depressed?
 John: Various since my late teens, early twenties. I had a severe nervous breakdown that began in 1966, and I was sort of in and out of the more acute episodes of it, on and off, for two and a bit years.

The medical diagnosis has legitimated his depression, and this legitimation helped him to accept his status as a psychiatric patient. He clearly relates his identification of himself as suffering from depression to the diagnosis of a medical condition. However, it is also clear that he has resisted this definition. He believes that he accepted it only because of the severity of his experiences.

- Siân: How does that make you feel, being diagnosed as being depressed?...
 John: I think it made things a bit easier and more helpful for me actually, in that in a sense before that it was like unacknowledged depression.
 Siân: Unacknowledged?

John: Yeah. And once it was acknowledged it in a sense became legitimate, so I became more accepting of it, I might not have done, I've had a lot of resistance to becoming a psychiatric out-patient.

However, he feels that the medical approach, although it has legitimated his experiences as depression, has not in fact attempted to tackle the cause of his depression. Instead he believes that the medical approach, in particular as seen in medication, is merely a strategy of management and control.

John: The word that leaps into my mind in describing the medical process is the word limited.

Siân: Limited.

John: Mmm. Limited ... It's important somebody kept an eye on me and so on at particular times.

Siân: What do you think the medical services are actually setting out to do?

John: I think one of the aspects of what they were doing was to make sure I was manageable, that's a lot of what the drug therapy was. And also there's a certain amount of discussion but it wasn't very much.

He can be seen to both resist and to use the medical discourse. He uses it, identifying and legitimating his problems, and he resists it, in limiting the function of medicine to one of merely management and control and not resolution. He believes that the problem is emotional rather than biological.

He explains his experience of depression as primarily caused by suppressed feelings. It is an emotional experience. In elaborating this he uses a model of the individual as containing emotions. Thus, the problem is contained within him. What he believes he needed was counselling, since that would have helped him to work through these feelings.

Siân: What would have been more helpful?

John: Counselling. Counselling, yeah.

Siân: Why, what would counselling have done?

John: It would have helped me to work through things, things that because of not being worked through have meant there was an awful lot of suppressed, difficult feeling around, and if I had to say there was any one thing that was behind my depression it is that.

1.2 The experience of depression

John indicated that depression itself could be a problem, but he also suggested that depression provided opportunities for learning and development.

Siân: Is one of the problems with depression, it's not depression itself maybe which is the problem, it's how you cope with it?

John: I think yeah, it is how you cope with it, but having said that for somebody... severe clinical depression, depression itself is a problem.

- Siân: Yeah. What about -, is the problem then getting stuck in the depression, rather than being able to move through it?
- John: I'd say so, yeah. And I think the depression itself is very significant. It's... I think at the end of the day... what we do with it.

Depression is here seen as a problem in itself only when extreme, as at the extreme of clinical depression. It is suggested that depression in itself may be meaningful and a way of learning about himself. This can be seen as providing an alternative account to the pathological account provided within the medical discourse. However, he also indicates that for him depression in itself has been a problem all his life, and one that he has had to learn to cope with. He identifies depression as a clear state. He also suggests that he has learnt to structure his life through and possibly around his experiences of depression.

- Siân: Over the years, has your experience of depression changed or is it the same?
- John: It's changed, I think initially, like in my early twenties, I didn't have the experience of life that I now have to help me to deal with it, you know, actually practising coping with working with a depressed state... much more life experience under my belt. When things look gloomy I can say to myself, 'It won't last, whatever's happening, it will always change.'
- Siân: So you believe that when you are very depressed?
- John: I think only to a degree. But I think part of where experience has helped is simply from having come through so much experience of being depressed and coming out of it.
- Siân: Yeah. Do you think you... learn anything from it?
- John: Yes, I think I learn how to manage... myself. I think the important thing that I learned from it really in a sense is insight, which I couldn't have in any other way.

While he is challenging the traditional account of depression as pathology, he is also clearly identifying himself as depressed. He suggests that throughout his life he has learnt to cope with himself as depressed and that his experiences of depression have been a major part of his experiences of life.

2. The self

In developing an alternative account of depression, John suggests that it can be understood as an experience of self. He suggests that depression is an experience of deadening the self, and that one way out of depression for him has to been to confront himself. He describes his experience of depression as a turning away from his own life, and from his own emotions.

- John: I'm sure sometimes it does, I think that's a very important ingredient if you like, of depression, is that there's a sort of shut-down aspect. Yes, I've used the word 'pattern', I think pattern's quite important, and I think there's a significant pattern in my way of dealing with the world, which

is in a sense a tendency to turn away from my own life. That may sound a bit odd, but the way I've dealt with particular difficulties in my family that I was born into, was to become withdrawn.

Siân: Yeah.

John: And so in becoming withdrawn I was, like, turning away from other members of family. But inevitably what happened along with that was that I withdrew from life in general, and from my own feelings.

Siân: Yes.

John: And that's quite profound, and actually having an awareness that this is a pattern which is there, and actually being able to change it is quite different. I suppose awareness is half the battle.

Thus, while seeing depression in terms of an individual problem, he also suggests that it can be viewed in terms of the self and in developmental terms, which are not necessarily pathological. He suggests that depression is a "shut-down" where he turns away from his relationships with others, from his life and from its meaning to him. So for him one way of dealing with depression was in a therapeutic community where he felt that he grew personally, and where he was enabled to confront himself.

John: It's as it -, it's a bit like you say, that people are a bit deadened, can be a bit deadened by depression, and I was still partially shut down, it [therapeutic community] was a very stimulating place. There's sort of, no escaping, the sort of - I think if anybody says, 'What's the hardest thing about that place?' I'd say, 'It's me.' 'Cause one is kind of confronted, you're confronted with your own picture of yourself, and your own blocks and vulnerabilities and so on.

Thus, he suggests that in his experience depression is linked to living, to self-development and to self-understanding. Depression is located in the individual, but this also suggests a potentially powerful view of self and of self-efficacy.

John: Because the relationship with ourselves is the relationship that we in a sense build all the others on, or run all the others on.

Siân: How do you think that relates to depression?

John: I think how it relates to depression is that it puts limitations on us, on what we can creatively experience.

Siân: Depression does?

John: Yeah. Because it sort of colours our view of ourselves and of the whole world and our sort of... to world if you like. You know, wanting to go and hide away.

Siân: Yeah. So in a sense it stops -, or does it stop people participating in living?

John: It does to a degree, yeah. It puts a damper on that. Well, you know, just going out of the front door even.

Here he describes depression as an experience of the self as powerless and as limited. He suggests that depression can be viewed as a process of loss of any sense of self-efficacy. Although this loss is contained within the individual, this is an implicitly social account, since he suggests that the sense of efficacy is built up through

relationships with others, and that the experience of depression is a turning away from those relationships.

3 Summary

This interview provides an example of the formulation of an alternative account of depression, to the medical and pathological account. Critically, it is an account where the experience of depression is constructed as meaningful to the individual, as part of a process of self development. It is a highly reflective account, which contains depression within the individual, but sees the individual as active in constructing meaning from experiences of depression. It is also suggested that the individual can themselves be effective in coping with depression. Depression is seen as a process rather than something which just "happens" to the individual.

John's account provides an example of resistance to the medical discourse. John can be seen to both accept the medical approach in its identification of depression, and as a tool for the management and control of depression, and to reject it as an approach to defining all of the experience of depression. The experience of depression has a meaning constructed through individual reflection on life experience and emotions, which is not consistent with the medical model of an objectively identified disease state.

INTERVIEW 3: PAT

Introduction

Pat was in his fifties. He had separated from his wife a number of years ago, and had two adult children and several grandchildren, whom he saw frequently.

He was a celiac (allergic to gluten) and had left work after a long period of illness. He had suffered for many years without the complaint being diagnosed and was accused by his first consultant of shirking work, although in intense pain. Eventually a second consultant diagnosed a serious complaint. He was furious at his treatment, which he felt was insulting and degrading.

He described himself as a past "workaholic". He had clearly enjoyed his work and responsibility in home life. While it might be that did not now have enough to do he rejected this idea, saying that he every reason to be happy. Themes in the interview were his questioning whether he was indeed depressed, self-blame for his experiences

of what might be called depression, and frustration at his powerlessness to change this experience, since he could not identify a reason for it.

He was receiving no treatment for depression and it was not clear that he had formally received a diagnosis of depression, although his G.P. had suggested him as a participant because he presumably thought he was depressed.

Analysis

1 What is depression? A moral discourse.

Pat said that he felt depressed sometimes but not continuously. He blamed himself for his depression and implied that he saw it as self-indulgent and self-inflicted. He felt powerless to act against it and very frustrated since he could not identify a reason for it. He can be seen as implicitly rejecting the medical discourse of depression as pathology because he does not refer to depression as an illness and because he implies that although it is a mystery to him it is a mood which ought to be in his control. He understands depression from within a moral framework, as a sign of his own weakness.

The question of what depression actually is was discussed during the interview. He approached the question of whether or not he was depressed by discussing what depression was. He defined it by reference to his own experience and also questioned whether his experience was depression.

He did not allow himself to "escape" into a medical discourse of depression as illness, something for which he was not responsible. This can be understood within a construction of his self as a powerful agent, who should be able to control his own moods and was responsible for his experiences. Depression remained a mystery.

- Pat: No I think that, that my form of depression, if you can call it depression, is er, as I said, it could be self inflicted and I should do something about it.
- Siân: But what could you do?
- Pat: But I don't want to get out.
- Siân: Yes.
- Pat: It's getting company and staying in company. Not to come home and start moping about. But I suppose this is depression. I don't want to do that. I suppose that is depression in itself, isn't it? Or is it?

Here the expression "moping about" suggests he views his behaviour as self-indulgent. He questions whether or not this behaviour is depression. He suggests that depression might be an unwillingness to go into company, and a preference for his own solitude. He also suggests that depression is when you feel so down that you want to see no-one. It is beyond the point where you help yourself by seeking company.

Pat: Because when you're down the first person you say hello to is liable to give you a lift - but when you're feeling really down, depressed in yourself, you don't even want to see that person.

He defines depression as lacking the will to change one's lifestyle, and to take positive action to enable improve one's situation. In this way, it can be seen as a state of powerlessness because there is no motivation to act. For him this action would be to go out to meet people, but he likes his own company.

Siân: What would you say is different in the way you feel when you're very unhappy?

Pat: Well, you're happy, I mean, you've got the means of, er, it's up to you to change, to change your style of life or something. But when you're depressed you haven't got that, I don't suppose energy is the word, but you haven't got the inclination. You don't want, you're quite happy in your little surroundings and - . That's how you feel at the time, yes.

Siân: Yes. And do you feel there's nothing you can do? Or would you wish - ?

Pat: I often say to myself, give myself a kick up the backside and get off and do something. But you're, to do that you've got to go out and meet people.

2. A Rational discourse

Pat sees his experience of depression as irrational. He is powerless to act because he cannot identify a reason for his depression. He is trapped between his belief in his own responsibility and a rational discourse within which depression is inexplicable. He is powerless to act when depressed and there is no available explanation for his depression, but since he sees depression as a matter of personal responsibility he is also to blame for it.

Pat: Well why should I be depressed? I'm not short of anything.

Siân: Yes.

Pat: My health is reasonably good. I can afford a packet of cigarettes and a cup of tea. I'm cheeky with, it aren't I? And so what have I got to be depressed about? I've got a brilliant son and a brilliant daughter and three lovely grandkids. I see my wife sometimes, ex-wife. So I've got nothing to be depressed about. Why am I depressed?

Siân: Mmmmm. Is it -

Pat: Now that's me. I don't, I suppose it varies with people, but what brings it on, what - ? Is it lack of interest or lack of work or - ?

Siân: Yeah, do you think it's important to know what brings it on?

Pat: Yeah, because you could do something about it.

3. Loss of role and identity

Pat also suggests that his experience of depression could be explained through giving up work. He had enjoyed his work, and gave the impression that it provided the

structure of his life: he still woke at half past five, the time he used to get up to go to work, and had extra hours to fill.

Through the available explanation of depression as occurring through loss of work, he is able to construct depression as something out of his control, in contrast to the theme of personal responsibility, above.

- Siân: Do you blame yourself?
 Pat: For?
 Siân: Being depressed.
 Pat: I don't know how I can blame myself because I didn't get on my knees and pray for it!
 Siân: Right.
 Pat: It just happened to come. But I do, I do definitely feel work had quite a lot to do with it. Because that clock, my clock doesn't alarm now but yet it alarms up here [pointing to his head].

The problem now is that he has lost his role, his identity and thus the capacity to engage. He suggested that he had enjoyed the responsibility of child care, which he had now lost (his children were now adults).

- Siân: I suppose it must have been quite hard, like, working all day and then having to come home and - .
 Pat: I lapped it up... lapped it up. Washing machine was going, the Hoover was going... brilliant. The responsibility, I used to like the responsibility.
 Siân: Is that what you miss now?
 Pat: I often thought about that but, er, I don't think so.

4. Summary

Depression was understood in moral terms, as a problem located in the individual and seen in terms of self-indulgence and personal responsibility. This provides an example of a strong alternative account to that of depression as illness. It is constructed within a moral framework, to which the medical discourse appears to be the only alternative.

The interview also suggests the potential power of the medical discourse, since the identification of Pat's experiences as depression is ambivalent and it may be that depression can only be clearly defined and identified within a scientific discourse.

Depression can be seen as an experience of loss: of employment, of life style and of identity. This is consistent with the interview with Angie, above, and with the interviews with psychiatric out-patients, where loss of employment is used as one explanatory framework for depression, as the result of a person's situation. This absolves the person from personal responsibility, within the context of that particular explanation, but it is not consistently used to explain depression.

PART IV DISCUSSION

This discussion will look at the significance of the analysis of the interviews with patients described in this study, for the psychology of depression and in the context of the development of this thesis.

The data analysis in Study II has sought to demonstrate that depression is an experience which is personal and meaningful. It has been shown that depression is an experience which is accounted for in terms of individuals' life experiences. This has several implications:

1. Explaining depression as part of life.

Individuals accounted for depression in terms which contextualised it within their biography. Often participants linked depression to specific events, for example Frank linked depression to unemployment and Douglas linked depression to retirement.

However, it should be emphasised that although some participants contextualised the onset of depression in reference to events, this is not to say that individuals necessarily saw it as caused by those events. What is notable is that depression is rendered meaningful in accounts in terms of an individual's biographical experiences. Events such as loss of work are themselves meaningful in terms of those experiences as a whole, and depression is not, for example, linked merely to the fact of unemployment, but unemployment is meaningful in the context of the loss of other important facets of the individual's life. So for example, Frank's loss of work meant that he was unable to pursue his hobby of restoring cars and could no longer go to the pub etc., and for Douglas retirement meant that he not only lost paid employment but also his voluntary and community based work.

This suggests that, contrary to the social science life events model of depression (see Brown and Harris, 1978; and Chapter One, Part II), life events are not themselves a sufficient cause of depression. What matters is the meaning of those events in the context of an individual's life, and that meaning is personal and subjective. This moves the focus away from a model of causation to an experientially based approach, where depression is seen as on-going experience which is *part* of someone's life, which has *meaning* in the context of their life and which cannot be clearly differentiated from, or objectively identified as distinct from, their life and biographical experience.

2. Explaining depression as an experience of self.

Depression can be conceptualised as an experience of self, as an experience which is subjectively meaningful but which moreover is directly incorporated into, constitutes and is constituted as an experience of self. What is the significance of depression as an experience of self?

Oatley and Bolton (1985) suggested that depression can be conceptualised as a loss of self, linked to the loss of an important role, as in unemployment, which is primary to the construction of self through role relationships. They claim to construct a symbolic interactionist model of depression. However, the analysis here suggests that the concept of role is questionable, since individuals fulfil many different roles, which are distinct and interlinked, and moreover since the concept of role is not particularly meaningful in terms of individuals' biographical accounts, where they are seen as having many different experiences and relationships. The concept of role is itself a social construct which may not be meaningful at an individual and subjective level. The self is constructed through experiences in several roles and relationships, and whereas role is a social construct it cannot be directly translated into experience at a subjective level.

For example, Pat had lost his employment through ill-health. Work was clearly very important to him. Although this is evident, his account of his experience is related to loss of work but also to his experience as a patient, when a consultant denied that he was ill, and his loss of his children as they have left home. These factors are important since they represent a loss of previous responsibilities which have structured his life. But they can be seen to operate at a subjective level in that they combined to give meaning to his life. The importance of these factors is not as objectively identified roles, but as experiences which gave his life meaning and provided a sense of purpose and this can only be addressed at a subjective level in looking at his account of experiences as a whole.

3. Meaning and adjustment

Similarly, Angie's account was concerned with the loss of roles in paid employment outside the home and this had direct implications for her identity, since she lost her identity as an autonomous and independent woman. However, what is at issue here is not simply a loss of role but taking on new roles as a wife and mother, and the process of adjustment involved here. She can be seen to attempt to construct meaning in her new roles, for example to plan to move to a new house which will be jointly planned and carried out with her husband as a couple. She is actively involved in negotiating a change of identity and this involved both loss and gain of roles. What is at issue is the meaning of the role to an individual as they attempt to re-construct their sense of self in

a process of change. This is further explored in relation to women's experiences of motherhood in Study IV, Chapter Eight.

What is at issue is the process of making sense of experiences and roles, and the process of adjustment. Marris (1974) argued that coming to terms with loss is a process of adjustment, as individuals attempt to reconstruct meaning in their lives through constructing new relationships, through which they could re-establish important sources of meaning which had been experienced in lost relationships. This is a process of reconstruction. For example, Chris had embarked on a management course, which he saw as a positive step which was to increase his chances of employment. At the same time he saw regaining employment as essential to his recovery. He could not understand his experiences as depression since he did not see himself as having suffered a major loss. The issue may not simply be one of loss of role as argued by Oatley and Bolton (1985) or of major life events (Brown and Harris, 1978) but of the meanings of events to individuals, which are constructed through their biographical experience as a whole.

4. Reflexivity

So far, discussion has indicated that what are important are the ways in which individuals construct meaning, or reflexivity (see Chapter Three, Part II). This issue is further pursued in Chapter Eight (Study IV). Here it has been shown that individuals construct meaning as biographically situated. For example, accounts of depression were constructed through biographical accounts, and from the standpoint of a particular point in the individual's life and their position within the social structure. This supports and draws upon Anthony Giddens' (1979) concept of *durée*, that meaning is the product of the individual's biography and current standpoint (see Chapter Three, Part II, section 2.2). It also indicates that the individual's position in the social structure is a vital consideration in the construction of meaning.

For example, the individuals interviewed drew on their experiences and roles as patients in constructing their experiences as depression. Angie, a general practice patient, and the out-patients interviewed, with the exceptions of Chris and Eric, had identified themselves as depressed following a diagnosis of depression, and the diagnosis validated their problems as real. For example, Angie had said that she felt depressed when pregnant, but this was not recognised until it came to light through a post natal survey score. This suggests that the experience of depression is only validated through becoming a patient and through entering the medical system. The acceptance of the diagnosis of depression as validating can also be seen to confirm the power of the medical system to define what is and is not a real problem of depression.

But the position of an individual as a patient within the structure of the medical system also has implications for their sense of self and identity. For example, Douglas said that he could not tell people what he was suffering from because they might think he was mad, and Chris that he found it difficult to tell his wife the diagnosis since depression was something which happened to other people and was stigmatising. Thus, an individual's sense of self and identity can be seen to be a product of their position within the social structures.

Individuals can be seen to reflexively construct meaning during interviews. For example, Chris initially denied that he had been depressed then, in reflecting during the interview upon his past experience, suggested that he might have been depressed in the past, as he reconstructed the meaning of the term depression and reinterpreted his past experience. The experience of self and the construction of self is a dynamic and on-going process which is the product of both present and past experience

5. The meaning of the term "depression"

The term depression has meaning, as constructed within accounts, as an illness and as a medical condition. Experiences are validated through the medical system and in particular through the diagnosis of depression, and this constructs them as clinical and medical problems.

The notion of depression as an illness is very difficult to reject. Thus Chris rejects the diagnosis of depression but has no alternative discourse available with which to construct his experiences, as either depression as constructed within a non-pathological discourse or as an alternative problem.

It is clear that depression is different to being unhappy. Martin, for example, said that depression was very different to what people meant when they said that they were depressed in everyday conversation. Equally, it is clear that it is a mysterious experience which individuals often cannot explain, as for Martin, Chris and Douglas, although others explained it with reference to their life experiences, for example Frank and Angie. However, it is not evident that a medical discourse has helped them to make sense of their experiences. The diagnosis is potentially liberating and pathologising in that it identifies and contains the problem and brings it within a field of recognised knowledge.

The interview with John suggested that he had only been able to make sense of his experiences through constructing them in an alternative discourse to that of the

pathology of the medical model: as an on-going experience of self. This did not entail a rejection of medical treatment but does imply an acknowledgement that medicine is not concerned with understanding or making sense of, but with controlling and managing, depression.

The medical discourse of depression as pathology is incorporated into the construction of the self as pathological. While it is liberating because it constructs individuals as not responsible for what has happened to them, it also by implication constructs them as irresponsible and uncontrollable except by medicine. This is also seen in interviews with women in Study IV (see Chapter Eight, Part II, Part C).

6. Issues identified in Study II to be explored further in the thesis

Issues which have been identified through the data analysis in Study II and which are explored further in Study III or Study IV are:

- i. Depression as an experience of self and identity. This is explored further in interviews with mothers in Study IV (see Chapter Eight), particularly in relation to issues of gender identity. It suggests that depression cannot be explained simply as a loss of self or loss of identity experienced in a particular role, but that it is complex. It is accounted for in reference to an individual's biographical experience and the subjective meaning of that experience rather than objectively identified issues such as role.
- ii. The experience of self incorporates structural issues, and cannot be seen as contained within the individual. For example, the identification of depression and the diagnosis of depression can be seen to be meaningful as the result of individuals' positions as patients seeking help within the medical structure, which is powerful in validating their problems and providing the promise of help, although not necessarily useful in terms of making sense of rather than simply labelling their experiences. Unemployment was a powerful issue in individuals' accounts of their experiences and is also a social and structural issue, which suggests that the experience of depression is constructed through the individual's social experiences and their social identity as unemployed, and that depression is not simply a problem contained within the individual.
- iii. The role of the medical discourse in identifying depression and constructing it as a pathological problem. This is further investigated in Study III, in the next chapter, where clinicians are interviewed about their understandings of depression, and clinicians' understandings of depression, and the construction of depression as a medical problem by clinicians, are more fully investigated.

CHAPTER SIX: STUDY III **HEALTH PROFESSIONALS' UNDERSTANDINGS** **OF DEPRESSION: DISCOURSE, DIAGNOSIS AND** **TREATMENT.**

INTRODUCTION

This study arose out of the identification of the importance of the medical discourse in Study I (see Chapter Two). There, it was noted that depression was legitimated and validated through the use of the medical discourse and that this discourse was powerful in defining depression as an illness, as located in the individual and as pathological. This indicated that individuals drew heavily on the medical discourse in constructing their accounts of depression.

In the interview study with patients (Study II) and the initial university study (Study I) a "medical discourse" had been identified, in which depression was defined as an illness and as a medical problem. The present study aimed to explore the medical discourse in greater depth, by interviewing those involved in the medical system as to what they understood as depression. Health professionals are an important influence on lay understandings of depression since, through treating depression, they come into contact with patients who are likely to see them as experts on depression. They also influence the wider lay discourse surrounding depression through the wider dissemination of knowledge about health through the media, which is incorporated into popular concepts and understandings of depression.

Further questions derived from the study of patients' accounts of experiences of depression. The analysis of patients' interviews had suggested that the diagnosis was critical in validating and legitimating patients' experiences of depression. One aspect considered here was therefore clinicians' understandings and concepts of depression, since they were the source of the diagnosis.

The motivation for Study III was to investigate health professionals' understandings of depression, in the context of what patients had said in interviews in Study II (see Chapter Five), and in particular given the identification of a medical discourse of depression in Study II and previously in Study I (see Chapter Two). So although, as will become evident, organisational issues and themes have are identified in Study III, and although I am aware that there is a literature pertaining to these issues, this literature has not been discussed here, since it is not the main focus of the study.

PART I DESIGN AND METHODOLOGY

Aims

Overall aim: To examine understandings of depression among health professionals involved in the treatment of depression.

More specifically:

1. To identify and examine discourses used by clinicians and health professionals in accounts of depression
2. To look at their definitions of and concepts of depression, and how these may be related to practice and treatment
3. To examine how health professionals' definitions and concepts of depression are related to experiences of depression in self and others, including patients, within accounts

Recruitment and procedure

Sample characteristics

The aim in structuring the sample was to interview as wide a range as possible of health professionals involved in the treatment of depression. This was to include medical professions, professions allied to medicine, such as nursing and health visiting, and professions with an emphasis on community work, such as social workers. There was a heavier emphasis on medical professionals though, as those who would have greater contact with depressed patients in treatment, and who would also be more powerful in influencing popular ideas about depression. The aim was to interview at least three psychiatrists, three G.P.'s and three clinical psychologists, and at least one member of other professions.

Participants were to be selected on the basis of their professional identity, and were to have worked in their profession for a minimum of two years. This was considered long enough to have accumulated sufficient experience within the profession. There was no upper time limit on experience, since the aim was to sample a range of professional discourses and an upper time limit did not appear relevant. Since selection was on the basis of professional identity, personal characteristics such as age and sex were ignored for the purpose of this study. Participants were, however, to be actively involved in working with depressed persons.

Recruitment procedure

Initial contacts were provided through personal contacts in the health professions, including a psychiatrist, and a counsellor in the non-statutory sector. Participants themselves then suggested others who might be interested in taking part in the study, and from the initial contacts the study snowballed.

Prospective participants were initially contacted by telephone. I explained that I was conducting a semi-structured, in-depth interview study on understandings of depression among health professionals, that the interviews were to be taped, were anticipated to last between 45 - 60 minutes, and stressed anonymity and confidentiality. For two G.P.'s and three psychiatrists details were left with a secretary and receptionist, who were telephoned again later to arrange an appointment for the interview.

All prospective participants contacted agreed to be interviewed. A time for the interview was agreed. The interviews were arranged at the participant's place of work, as the most convenient location.

Participant characteristics

26 clinicians and health professionals were interviewed. These were: 5 psychiatrists, 4 G.P.'s, 3 clinical psychologists, 4 G.P. counsellors, 1 community psychiatric nurse, 2 psychiatric nurses working in hospitals, 2 health visitors, 2 social workers, 1 cognitive (nurse) therapist, 1 art therapist, and 1 occupational therapist.

(In-depth analysis of data from the interviews with G.P.'s, psychiatrists and clinical psychologists only is presented here, because of limitations of time and space within the thesis, but this analysis was informed by preliminary analysis of all the interviews.)

Interview design

An interview schedule was used (see Appendix D). As stressed in Study I (Chapter Two) and Study II (Chapter Five) the aim was to focus on the participants' own perspectives, experiences and understandings. However, in this study, given the limited time available to most participants, the interview schedule was used to initially focus the interview and to make sure that major areas were covered in the time available. The interview schedule was however not used to dictate questions in the interview and was used flexibly as a guide to areas to be covered and as a prompt. Areas were not necessarily covered in the order listed on the schedule, and the emphasis was on pursuing the interests of the participant.

The interview schedule focused on the participant's understanding of depression: what it is to experience depression, prevalence, causation, the significance of the diagnosis and the meaning of the term "feeling depressed". The aim here was to cover a range of understandings of depression, to identify the significance of depression as a medical condition and to identify what participants understood as experiences of depression. Developing this, the schedule also covered how participants assessed depression in patients. Lastly, the schedule looked at professional roles in the treatment and assessment of depression, personal reasons for choice of career, how participants described their professional relationships, and their personal skills. The aim in the interview was to look at approaches to depression within the context of professional role and of personal interpretations of and motivation to fulfil that role.

Interview procedure

As stated above, interviews were at the participant's place of work. Interviews lasted between twenty minutes and two hours. The process of interviewing can be divided into three stages, as in Studies I and II:

In the first or warming up stage of the interview, the information given in arranging the study was reiterated, and in particular clarified to those participants contacted through their secretaries. The participant generally asked further questions about the research at this stage, and these were answered. The participant was then given a copy of the interview schedule and, after this had been read, the tape recorder was turned on.

In the second stage, the issues noted above were discussed while flexibly following the individual schedule.

In the final stage, the interview was wound up as discussion was brought to a conclusion. Participants were asked if there were any issues not covered which they thought important, or if they had any comments they wished to make. They were also asked for any feedback on the interview.

Transcription

The interviews were transcribed verbatim, as in the exploratory study, some by myself, others using secretarial support. More detail about transcription is given in Appendix B.

Analysis of Interviews

It should be noted that more details about the mechanics of the methodology are given in Appendix B.

The analysis of the health professionals' data is described here in three phases. In these phases, the methods outlined in Chapter Two (Study I) and Chapter Five (Study II) were used but developed with a different emphasis. In particular, there is less emphasis on the coherence of individual accounts and the individual's attempts to make sense of their experiences within their account. In Study III, the emphasis was rather on constructing themes across accounts and looking at the variability between accounts. Although this meant incorporating an analysis of variability within interviews, there was less concern than in Study I and Study II with the internal coherence of accounts and with relationships between themes within accounts. In the analysis of interviews in Study I and Study II, the emphasis had been greater on maintaining a focus on individual experiences and interpretations of experiences and sense making within accounts. This is a difference of emphasis rather than of method, since identifying themes and looking at the relationship between themes across accounts depended on some analysis of their use and relationship within accounts.

The method of analysis used in this study also differed from Studies I and II in that themes which emerged from earlier phases of analysis in Study III clearly informed and shaped subsequent analysis. As the analysis proceeded emergent themes were identified which then determined:

- a) The structure and content of the data base in the subsequent phase(s) of analysis,
 - i) whether analysis was structured at an individual level, across interviews, or at a group level as in the analysis of interviews in professional groups.
 - ii) the selection of specific interviews or groups of interviews for further in-depth analysis.

- b) The conceptual basis of subsequent analysis.

Phases of analysis

The emergent process of analysis is here described in terms of phases of analysis.

Three phases of analysis can be identified. Each phase informed subsequent phases. However, they incorporate different approaches to analysis of the data, and should not be read as a strictly followed sequential or stage model.

Phase 1. Discourse analytic techniques and organisational processes

This phase involved using all the data in preliminary and repeated reading of the transcripts, identifying themes within and across interviews.

Analysis in phase 1 commenced using discourse analytic techniques to identify medical discourses as used in clinicians' accounts of depression. It can be seen as analogous to, and drawing upon, the analytic method developed in the Study I. But a bureaucratic theme, of the importance of organisational processes in defining depression, was also identified in reading the data. This indicated that an analysis of discourse was insufficient.

Phase 2. Organisational issues: in-depth analysis of selected themes across interviews.

This involved use of interviews in an across interview analysis, the initial identification of themes across interviews and the subsequent in-depth analysis of selected *themes* across interviews. The focus of in-depth analysis was then selected themes which had been identified in preliminary analysis across interviews.

Analysis in phase 2 was informed by phase 1 and focused on organisational and professional issues in the definition and treatment of depression. This was distinct from the original discourse analytic approach, but also incorporated it. For example, a treatment discourse of depression had been identified, which could also be seen to define professional functions when understood within the conceptual framework of organisational processes.

Phase 3. Professional issues: thematic analysis.

Data were analysed within professional groups, and interviews with psychiatrists, G.P.'s and clinical psychologists were selected for this (point (a) above). Themes and issues emergent from phase 2 determined the focus of analysis in phase 3 and determined the structure and selection of the data base used. This involved an in-depth analysis of interviews on a within interview and between interview basis, as explained in the description of thematic analysis in Study II, (see Chapter Five, Part I).

Analysis in phase 3 was informed by the identification of professional functions and roles within the organisation of health care, and their importance in shaping understandings of depression, as identified in phase 2. Thus it focused on the professional identity of participants and sought to identify distinct professional approaches to the understanding, identification and treatment of depression.

Details of themes identified in the three phases of analysis.

Details of themes which emerged from phases of the analysis are given below. These suggest the multiple ways in which data may be analysed rather than the possibility of an exclusive and sufficient perspective. A different perspective was taken in each phase of the analysis and there was considerable overlap between phases of analysis. The research account to be presented in this chapter emerged from phase 3 of the data analysis, but was informed by previous phases 1 and 2 of the analysis, and incorporated work from them. The results of phases 1 and 2 of the analysis are not fully discussed here, because they were used to inform phase 3, and because of constraints of time and space.

The listing of emergent themes, below, is designed to give some insight into the complexity and progress of analysis through the phases, and to provide some examples and understanding of issues which arose, illustrating the complexity and range of the analysis. More details of methods used are also given for this purpose. It is not designed to discuss issues in depth. A full account of the findings in phase 3 of the analysis follows in the results section.

Phase 1. Emergent themes.

The initial overview of the data identified as important issues:

1. The importance of organisational factors in shaping understandings of depression.

It was suggested at an early stage in the analysis that the focus might be not only on discourses surrounding depression but also on the importance of organisational processes. For example, organisational factors might determine who defined cases of depression, who treated cases of depression and who had responsibility for the outcomes of treatment.

2. The influence of doctors within the organisation of health care.

While there was some divergence between professions and between individuals in their views about depression, the medical model was powerful. Individuals who rejected the medical discourse of depression as an illness had difficulty in constructing an alternative discourse.

There was thus considerable tension between the dominance of doctors in health care and the status of other professionals who, on the one hand, were autonomous professionals with a distinct knowledge base and, on the other hand, were operating in practice within the limitations of the medical model and were accountable in the terms of that model. For example, health visitors interviewed had distinct understandings of

depression as a social and community problem but also referred severe cases to their G.P.'s.

3. The medical model was an important symbol in the organisation of health care, and participants positioned themselves as either elaborating or rejecting the model. The medical model was seen as a model of depression as illness and as pathology, where depression was understood as located within the individual and internally caused by some malfunction of the individual, whether physical or mental.

Phase 2

In this second phase of analysis, building on the overview of the data in phase 1, it was decided to focus upon the importance of the medical discourse in formulating definitions and understandings of depression. Beyond the focus on discourse, there was a concern to identify organisational factors. These included looking at:

- a) the individual's approach to depression as a member of the health care system and as a member of a particular profession, and
- b) the importance of medical processes in defining depression.

In phase 2, interviews in the data base were used in three ways:

- a) To provide background information and inform the development of themes across interviews. Although the research account has concentrated on selected interviews, in presenting data this phase involved repeated reading of a wider base of interviews which then informed the analysis of other specific interviews in later stages.
- b) To inform a general awareness of professional issues in the treatment of depression within the health service. This involved repeated reading and the identification of themes within interviews.
- c) In-depth analysis of *themes* across interviews.

Emergent themes in phase 2:

1. Medical discourses.

Medical/ clinical discourses were identified, for example discourses which identified depression as a biological problem, as an illness, or as a medical problem, or which were broadly based around the medical model. Whereas in phase 1 the importance of the medical model had been noted, the medical discourses noted here were discourses used to construct depression as a medical problem. Emphasis was also placed on the

identification of discourses which could be seen as alternative to those based around the medical model.

2. Organisational factors: the organisation of the health care system and health professions.

This included the importance of the medical process as the means by which problems such as depression became identified as medical problems: for example, whether a problem was medical because a person consulted a doctor, or whether it was defined as medical according to definitions of professionals' functions, and whether referral processes in effect defined a problem as medical or non-medical. For example, was a problem a medical problem if a health visitor advised a woman to visit her G.P., but at the same time understood the woman's depression as related to her social situation and encouraged her to attend a support group? The emphasis here was on organisational processes, rather than the abstract notion of depression as an illness, or the medical model, as described above in phase 1.

3. Dominant values in the health care organisation.

Medical values were identified as dominant within the organisation of health care, for example in whether severe cases of depression were seen as medical problems. Doctors referred cases on to other professions, as G.P.'s did to social workers, counsellors, psychiatrists. The professional values of medical specialities might also influence definitions of depression. For example, G.P.'s and psychiatrists defined depression in different ways through the diagnosis. They had different professional concerns linked to their functions and positions in the health service. For example, G.P.'s were positioned at the point of entry to the health care system, and were able to define depression as a medical problem needing medical treatment or as a psychological or social problem needing psychological treatment or social action. Psychiatrists were seen as the medical specialists in mental health, redefining problem cases referred on to them within the terms of professional psychiatric codes, for example DSM-III-R (American Psychiatric Association, 1980, 1987). (See the analysis of interviews with psychiatrists and G.P.'s to follow).

Phase 3

Analysis within and between interviews had indicated that the participant's particular profession was an important factor in shaping themes in understandings of depression. While themes could be identified which crossed professions, the particular professional status was vital in the structure of treatment and practice and the delineation of functions for individuals, and reflected the role and importance of particular professions

within the organisation of health care. It was therefore decided to look at how understandings were constructed within professions.

The next stage was, therefore, to look at themes across individuals' accounts within professions, using the data sets from G.P.'s, psychiatrists and clinical psychologists. These professions were chosen because they included the medical professions, G.P.'s and psychiatrists, who had treated patients interviewed in the Study II, and because clinical psychologists could be expected to draw upon psychological approaches.

The preliminary analyses of individual professionals' interviews were reread, together with notes on emergent themes. On the basis of this, it was possible to identify links between themes and to reconstruct themes, as links became clearer through the pooled interview data and as the structure of professional practice became clearer to the researcher. The importance of some themes was emphasised, some themes were restructured and some were subsumed into overriding themes which were identified across the data. Through this process, a structure or framework of analysis emerged, which was built up from consideration of the data, of the themes identified and through reflection on the significance of these themes. The structure or framework of analysis included, for example, the degree to which individuals identified with their professions, the relative power of professions, the degrees of autonomy and freedom experienced by individuals and issues of responsibility and accountability.

During this stage of analysis it became clearer that while one factor in the analysis was attention to the discourses used, this in itself was insufficient since another factor of overriding importance was medical processes. This included consideration of the role of medical processes as a dynamic, which in itself explained why individuals received medical and psychiatric attention and why problems became defined as medical or psychiatric problems. It also included looking at the power of the medical process, and the distribution of power within the organisation of health care.

Details of the themes which emerged from phase 3 of the analysis are fully discussed below, in the results section of this chapter (Part II).

Summary of emergent themes

In each profession different themes were identified. The importance of looking at both discourses and organisational factors became clearer and gave an overall structure to the analysis. The medical discourse was seen to be structured from an assumed basis in medical science, located in the medical process and interpreted through the medical process, including professional considerations. The medical model had a symbolic

function within the organisation of health care as a core value, against which individuals positioned themselves, in accepting or rejecting the medical model. Issues of discourse and process are distinct but related, since medical discourse is itself a product of and reflects medical processes. The medical process itself was seen to determine the function of the medical discourse, and the ways in which the medical discourse was interpreted and applied in practice. The medical process could also be seen as marginalising discourses other than the medical discourse, since alternative approaches were not admissible or were not powerful within the organisation of healthcare.

Concluding comments on the process of analysis.

The process of constructing an analysis was based on the identification of themes. This was combined with an awareness of the importance of looking at both discourse and organisational factors. The process of analysis was not purely an inductive process where the researcher was neutral but, as discussed in Chapter Three, the researcher is active in constructing the research account, for example in selecting themes for further analysis and actively constructing a conceptual framework. This is a reflexive process, the researcher drawing on her own knowledge and experience.

Phases of analysis also illustrate that the construction of a research account is an ongoing and dynamic process, that the researcher's perspective changes through doing the research. In addition, the analysis can never be completed although brought to a point of conclusion. It should be noted that the themes listed above have not been fully developed, due to lack of time and since the focus of analysis shifted and became more specific, and thus have been noted as *emergent* in the process of analysis.

Part of the concern within the process of analysing health professionals' accounts was to explore the range of issues in accounts, and to also focus down on particular issues in order to present a coherent analysis. This involved taking some subjective decisions in selecting data, discourses and themes for further analysis. The analysis presented here (Part II, below), which emerged from phase 3, is therefore not a complete summary of the research findings but presents results within a particular conceptual framework, which emerged from preceding phases of analysis.

PART II RESULTS

The data analysis resulting from phase three is presented and structured according to professional groups (of psychiatrists, G.P.'s and clinical psychologists). The analysis of interviews with psychiatrists is presented first (Part A), then the analysis of interviews with G.P.'s (Part B), and lastly the analysis of interviews with clinical psychologists (Part C). These are presented as distinct analyses and implications from all three analyses are discussed in the final part of this chapter (Part III).

While data from other professionals interviewed for Study III have not been presented in this chapter, and were not included in phase 3 of the analysis, the approach taken in phase 3 could have been used with other professions. The preliminary analyses of interviews with the other professionals was also critical in informing the analysis presented here, especially as regards the prevalence of the medical discourse.

PART A : INTERVIEWS WITH PSYCHIATRISTS

1. Defining depression

1.1 Organic and biological

The construction of depression as a medical problem depends on the assumption of biological causation. Depression is seen as a biological condition and as a medical condition and as such distinguished from unhappiness. This assumption is not supported in terms of scientific research and is acknowledged here to be a guess, based on the definition of what is an illness. There is no attempt to construct depression as a proven medical problem in scientific terms, but it is constructed as a medical problem based on the assumption of biological causation and identified as an illness. In practice depression is identified through symptoms.

Dr. K.: Well, depression's a word of several meanings. When I use the word depression, I mean it amounts to an illness and I distinguish from being unhappy. So when I use one word depression I'm implying a disturbance of function, I'm implying that there is a biological, physical basis, in other words I'm taking an organic view and sometimes there may be an apparent cause and sometimes there may be no apparent cause. All causation in psychiatry is guesswork in the present state of non-knowledge. So I separate out depression as a biological illness, in which the mental accompaniments are the ones that are the most prominent and the symptoms which we use as a handle to grasp the patient by. Though my guess is biochemical changes are what's causing it all. And what I call the other things are unhappiness and part of the human condition.

1.2 Psychiatric illness and diagnostic systems

Psychiatric illness may be distinguished from depression. The function of the psychiatrist is to deal with clear cut psychiatric illness and not with depression as a whole. Psychiatrists have no particular expertise in depression and only and exclusively in psychiatric illnesses.

Siân: So would you clearly differentiate between depression as an illness and depression as unhappiness or feeling blue?

Dr. D.: No. I would say that there are psychiatric illnesses. I believe that. That's my job to treat that. The rest of depression, I'm just like any other lay person. Uses the word just like the rest of the population.

Siân: Does that mean you see it as a continuum then, or...

Dr. D.: No, No. There are all degrees of unhappiness, from feeling suicidal to slightly miserable. But that's absolutely nothing to do with mental illnesses... There are quite clear cut psychiatric illnesses.

Depression may be identified exclusively as a mental illness and in terms of psychiatric syndromes, which are seen as encompassing all experiences of depression, not as distinguishing depression from psychiatric syndromes. Within the category of depression there are a range of psychiatric syndromes.

Dr. V.: Do I think there's such a thing as depression and, if so-. Do I think so, yes. How would I define it? I would define it syndromically. In other words, by symptoms and signs. So I would have probably seven or eight different syndromes of depression I would have in my head.

Siân: Different types of depression?

Dr. V.: Different categories within say ICD-10 or DSM-III-R. I would have major depression and then subcategorise it, either non-psychotic, chronic, non-chronic, melancholic, non-melancholic, seasonal, non-seasonal and so on. You've a major depression. Then you'd have unipolar or bipolar. Then you'd have dysthymia, minor depression, recurrent grief depression. So there are a whole different number of sets of syndromes when people talk about depression to think of.

Depression as a psychiatric problem is identified on the basis of symptoms. Causation is unclear, and although there is a biological component it is not known at what level this works. A biological component is evident because some symptoms of depression are clearly biological and physical.

Siân: You'd call it an illness?

Dr. V.: Now, that's one thing. These are symptom definitions. Now what do I think is the cause of all that? I see these symptoms as a result, an end-point biological dysfunction. That's not the same thing as quite saying an illness. But I would locate depression in the brain and see it as a result that certain neuro-transmitter pathways in your brain if they have been subjected to excessive stress over a certain amount of time begin to dysfunction. And the produce of that dysfunction's what we call depression. And I think that can equally happen for a whole variety of reasons, psychological right through to biological and genetic.

The aetiology of depression is unclear, but this is not rendered important within a symptom based diagnostic approach, where mental illness has been defined in terms of symptoms alone. A biological component defines a problem in terms of mental illness, although the role of biology in causation may be unclear. Within this narrow approach to patients' problems treatment may be exclusively biological.

Dr. D.: For people with a very clear-cut mental illness, whatever word you use, because there are many different words, endogenous depression, biological depression, ICD-9 classification, manic depressive illness, then there's clearly a very strong biological component, and I treat it by biologically means.

It is not clear that the knowledge base of psychiatry has meaning outside the medical process. For example, another psychiatrist suggested that the diagnostic system DSM-III-R is a professional and not a scientific document, which was drawn up in order to justify the work that psychiatrists do and which attempted to clearly identify mental illness in terms of psychiatric professional needs, but in which the complexity of the patients' experiences was ignored. It is a document whose relevance is limited to a justification of the functions of the psychiatric profession. Mental illness as categorised within DSM-III-R has little relationship to individuals' experiences.

Dr.P. And there's lots of problems with DSM-III-R. I mean, essentially it's a nonsense now, sort of criteria, because psychiatrists wanted to defend their discipline so this is the Bible, presented to give psychiatry the authority to go on doing what it's doing. It's no more than that at the moment.

Siân: So it's not useful?

Dr. P.: Not useful at all. Well, I do suggest that trainees read, I mean some of the descriptions of people's feelings are useful, but I also point out to them that although DSM-III-R claims it's got all this authority there's in fact no references at all in the whole book. No references at all.

Siân: How did they come up with it?

Dr.P.: There was this consensus panel, I think of 100 psychiatrists, who compiled it originally, spearheaded by a chap called Robert Spitzer who was, who sort of led a crisis, I would say he had some sort of personal crisis over psychiatry because of the anti psychiatry movement... obviously he had a great sort of crisis with that, because Rosenhan was saying, you know, what are psychiatrists doing, they can't diagnose mental illness, they've admitted these people, and there's nothing wrong with them. So Rosenhan was saying psychiatrists are unable to diagnose mental illness. So DSM-III actually is a reply to that, to people going round saying psychiatrists cannot diagnose mental illness, DSM-III says psychiatrists can diagnose mental illness, it's here, this is it, this is what mental illness is, it's in this book.

1.3 Distress

In conflict with this, there is no distinction between the idea of depression as a biological condition and depression as distress and unhappiness. They are all within the remit of psychiatry.

- Siân: Can you distinguish between, well there's depression as a mental illness when it's psychotic, but in other ways can you distinguish between depression and distress.
- Dr.P.: I suppose not, no. I mean, I'm using the term depression in a wide sense and distress might be just as good. Or disillusion or something would do as good, or demoralisation or, I'm using depression in a very wide sense.

This psychiatrist was concerned to establish a non-biological model of depression, and believed that treatment through medication and the biologisation of depression which was consequent on medication was unhelpful, and a hindrance in helping people to come to terms with their experiences of depression.

- Dr.P.: If it's [depression] interpreted as a biological thing that can be a danger.
- Siân: Why?
- Dr.P.: Because it's not right. Because um... I'm not sure if it really helps people to deal with their problems by accepting that model. I don't think it does actually, it can lead to all sorts of problems. I mean, parts of my job as a psychiatrist is dealing with people who do believe that and are told that and they're stuck on medication and when people are on medication it's difficult to get them to see otherwise. Um...
- Siân: And why have they come to believe that?
- Dr.P.: Because it's been their experience that when they've been on medication they've felt better. But that's not necessarily the effect of medication, because medication's very powerful in the sense that it raises people's hopes. Also doctors do say that there's something wrong with the brain, a lot of people believe it.
- Siân: So what kind of skills do you in particular have?
- Dr.P.: I guess, I mean I'm not sure this is, I mean I am determined to develop a much more sort of coherent non-biological model than there is at the moment in psychiatry.

The suggestion that treatment through medication leads people to understand their problems as biological is consistent with the analysis of some out-patients' interviews where it was found that for some patients, but not all, treatment through medication seemed to lead to an understanding of their problems as biological, and biochemical (see Study II, Chapter Five, Part II).

1.4 Experience as illness

The identification of depression as a medical problem, if not linked to its identification in terms of psychiatric knowledge, is based on the ability of doctors to deal with what patients experience as illness. Here the psychiatrist is seen as dealing with problems

that patients understand as illness, rather than judging whether or not they are mental illness, on a pragmatic and empirical basis.

Siân: Is medical training very relevant then?

Dr.P.: Well, only in the sense that it is connected with illness in general. That's the only way in which it's relevant to me.

Siân: Sorry, how's that help?

Dr.P.: That mental health problems are connected with illness in general. I mean, I'm not going to go on about illness but that's deliberate, that would include sort of psychosis but I'd want to actually say that mental illness is more than that, it's partly to do with the way that people feel ill. So, er, will go to doctors when they're not well. And that must include psychological illness. So only in that sense is it important to have a medical training. In a lot of ways it's a disability.

1.5 Summary

There is considerable variability and confusion in definitions of depression. Connected to this, there were different and contradictory understandings of the remit of psychiatry in treating depression. Depression can be understood as a broad term encompassing distress, or can be defined through psychiatric diagnostic systems, and within these understandings is seen as lying within the remit of psychiatry. Alternatively, the role of psychiatry is seen as dealing with specific psychiatric illnesses which are distinct from and distinguished from depression. The diagnostic systems are symptom based and within them depression is constructed as an illness in terms of the medical model. The presence of biological components means that depression is identified as a biological illness and that there may be an assumption of biological causation.

Thus psychiatrists interviewed can be seen to have variable and distinct understandings of concepts of depression and of depressive illness. Most clearly, these concepts may be defined with reference to diagnostic codes but the validity of these remains unclear, particularly where they are distinguished from, rather than related to, people's everyday experiences of depression.

2. The remit of psychiatry: treatment

2.1 Biological/ social

If depression is seen as a biological disorder, then the effectiveness of psychiatry is seen in terms of providing a biological solution and is limited to dealing with biological aspects of the patient's problem.

Siân: Are there any aspects of the patient's problem that you can see that is not your remit to deal with?

Dr.D.: Most of them. My remit's very small.

Siân: So is that-.

Dr.D.: We're fairly irrelevant.

- Siân: Psychiatrists are fairly irrelevant?
 Dr.D.: Yeah.
 Siân: So what can you hope to do for them?
 Dr.D.: If they have a biological disorder, then we can offer them the best, anything that we can manoeuvre, we can do whatever we can for that. If we felt they needed some kind of psychological therapy, if you had time you might provide it, if not you can refer... But we have absolutely no effect on anybody's housing, financial situation, social situation, relationships, number of children they have or don't have, whether they go out and get drunk the night before...
 Siân: So can you really do very much at all?
 Dr.D.: Oh, a small percentage of people, yes.

In contrast to this, if understanding of depression as a psychiatric problem is not confined to a biological concept of depression, then treatment is on a psychological basis, in terms of providing an acknowledgement of social factors and personal circumstances and enabling the patient to come to terms with these. Here, the understanding of depression is related to circumstances external to the individual and depression is not seen as contained within the individual:

- Siân: So what sort of treatments do you end up giving.
 Dr.P.: Well, I don't know, relationship based, talking to people. I mean I do use medication as well. Um, and er, also recognising the importance of social works. It's always difficult to interfere as it were in people's social environment but at least recognising problems of the social environment can be important in treatment.
 Dr.P.: I guess that's what treatment is, it's helping people to, you know, come to terms with their situation.

The distinction between the concept of depression as a problem contained within the individual, often understood as biological, and the concept of depression as related to the individual's circumstances, reflects the explanatory frameworks identified in out-patients' accounts, where depression was accounted for in terms of the individual's situation or as a problem of self, as something wrong with the individual. The distinction between depression as explained through individuals' circumstances and explained as a problem with the individual, can also be seen in the analysis of interviews with G.P.'s (below).

However, within both types of account - of depression as a problem contained within the individual, and of depression as related to social factors - there is an acknowledgement that the psychiatrist is only empowered to work with the individual, and cannot be effective in changing social circumstances. A distinction is that within the first account the individual is the focus of the problem, but in the second account

the importance of the individual's understanding and experience of problems as part of the social environment is acknowledged.

2.2 Research basis/ pragmatism

On the basis that there is no clear distinction between depression as an abnormal condition and as a normal condition, then there is no limit to what can be treated and the remit of psychiatry is potentially infinite. Psychiatric problems are defined in terms of what responds to treatment rather than in terms of what is defined as abnormal.

Dr.V.: So for me my threshold of treatability is decreasing all the time. I think as research changes, an idea of what's normal or not, but there doesn't seem to be any clear definition between what's normal and not. There's some evidence you can treat normal grief as depression and improve it. So I actually have no ideological idea of what's normal or not in my head.

But treatment may also be seen as highly empirical and a question of individual judgement, rather than based on clear knowledge about the problem.

Dr.K.: I think the important thing is, is that if you're in psychiatry because of its uncertainty and lack of fundamental knowledge of what's happening in the brain, how does the structure of the brain translate into a mental life we experience as consciousness, nobody has the faintest idea. And because of that very fundamental uncertainty you end up having to solve a hopeless philosophical conundrum. And therefore you can't help but put your own personality and prejudices into it, whether you want to or not, because somehow on the basis of inadequate knowledge you'd like to do what you can to help people who are unarguably suffering. And how you handle that is a matter of your own personality and that's why psychiatry remains a one-man band.

2.3 Summary

There is evident variability and inconsistency in approaches to the treatment of depression: between approaches which contain the problem within the individual and approaches which see depression as explicable in terms of social experiences; and between approaches which see treatment and definitions of depression in the practice of psychiatry as research driven, and those which see treatment and practice as pragmatic and individualistic.

It is unclear what the knowledge base of psychiatry is, and it is indicated that there is no clear and consistent approach to the definition and treatment of depression. Psychiatric definitions and treatments of depression may be explained as clearly defined and as research driven. But interviews with participants who more directly addressed the complexity of experiences of depression, the uncertainty of medical scientific

knowledge about depression, and the importance of social factors in depression, indicated the need for a more pragmatic approach based on the needs of the particular individual. Common to all approaches is a focus on the individual, which avoids explaining depression as a complex, social experience of a person in their daily life.

3. The medical process

3.1 Procedure

Mental illness may be defined with reference to diagnostic systems and the diagnosis may be given in terms of these systems. Diagnostic systems are used to define problems in terms of mental illness. They are self-contained and have validity within the psychiatric profession. But they can be used to provide a diagnosis which is not necessarily meaningful within the terms of a patient's experiences or of common understandings of depression. The assessment is constructed within, and may only be meaningful within, the terms of the medical process and the psychiatric profession.

Thus in this excerpt the assessment is understood in terms of medical processes and the notion that it should relate to the patient's experiences is rejected:

- Siân: So at what point can you distinguish between somebody who's depressed, feeling blue in the sense that everybody does sometimes, and somebody who's depressed, needing treatment.
- Dr.D.: People come to a service because they are, we're a secondary service, we don't take people off the streets. People come to us by referral. So if somebody sends them up, we don't go and say to somebody, we'll see if you're depressed, we have people sent to us. And it's my job to assess what's wrong with them... and we would assess what's wrong with them and make a formulation, a diagnosis. And the word 'depression' will be used within that because we have no better words to explain lots of different things.

The problem of identifying depression is here reduced to that of following bureaucratic medical processes. This suggests that there is no variability within assessments and that problems can be clearly defined within psychiatry. It is suggested that knowledge is clear and certain, whereas what is actually outlined is the processes through which the psychiatrist passes in order to formulate a diagnosis. This suggests a bureaucratic model, in which processes are used to contain the complexity of the problem.

- Siân: So is there any way that you would say your assessments are different to those of other psychiatrists, or-?
- Dr.D.: No. All psychiatrists in training are taught to take a case-history, which they've been programmed into as medical students, and this is exactly the same. They're programmed into it. They can't pass Part I of their Membership... without passing a clinical, at which they have to deal with a patient, present a history... in the presence of an examiner, produce a formulation. Can't pass Part II without doing the same, without

producing a management plan. And they are programmed into it. And in law, you know, you have to do it, that's what you have to produce, a report, that's what you're expected to do. So we're a programmed machine. On which people have spent a great deal of money.

3.2 Management and control

Depression may be seen as a medical problem, not because of the medical knowledge available but because people perceive their problems as illness and so enter the medical process. Within that process, doctors are taught to act within a mechanistic approach. Within this approach, the problem may be seen as one of control and management rather than resolution. It is claimed that the advantage of medical training is that doctors are taught to act and to deal with uncertainty.

Siân: So why in a sense would be that best people to treat depression? Would it be doctors or... ?

Dr.K.: I think doctors. Not because I think we're inherently kinder. On the whole doctors are more callous than most because if we weren't we wouldn't survive the professional lives we have to lead. Because doctors are trained to look past the tears, look for symptom clusters and think what can I do about it. And as doctors are trained to have a mechanistic view. And while the mechanistic view isn't the only view and in certain circumstances isn't the best view, it is the view that gives you an approach to actually do something as opposed to weeping and sobbing while nothing happens. So that kind of training in some ways is an advantage. Because you'll actually do something. Primitive and uncertain and perhaps not based on sound knowledge as we would like.

The complexity of problems of depression is acknowledged here. The responsibility and expertise of doctors is seen to rest on putting into practice medical processes, as suggested above in section 3.1, rather than on their knowledge or ability to resolve the patient's problems. The basis of action is procedure rather than knowledge. It can be characterised as bureaucratic rather than scientific.

4. Summary and conclusions

Two broad themes emerge from this analysis: a bureaucratic discourse which emphasises the importance of the medical process and of the medical system, and a professional discourse which emphasises the role of diagnostic systems as professional documents in identifying depression as a psychiatric problem.

A bureaucratic discourse has been identified, which emphasises the ability of doctors to act and follow through medical procedure, whereas scientific knowledge, explanations and ability to resolve depression is uncertain and unclear. The question of what depression is, is avoided where it is redefined in terms of psychiatric diagnoses which are not easily related to what people themselves experience. Alternatively, psychiatrists

may see themselves as dealing with all forms of distress, when their remit is effectively defined in terms of who arrives in their offices through the medical system.

There is an emphasis on diagnostic systems, used to identify depression in terms of psychiatric syndromes, or to identify psychiatric illnesses which are seen as distinct from depression. Contradicting this, there is an emphasis on distress, as experienced as and defined as an illness by the patient and thus falling within the remit of psychiatry.

There is a distinction here between, firstly, an emphasis on the patient's experiences and, secondly, an emphasis on the medical system and medical processes and professional psychiatric diagnostic systems. This distinction can be seen in terms of a distinction between an approach centred on the patient's experiences and the patient's understandings of those experiences, and an approach constructed within the medical system. The prevalence of the medical system, and issues of professional identity and power within that system, may go some way towards explaining why the diagnosis of depression, although liberating for patients since it validated their problems, is also inadequate as an explanation and in providing a resolution of these problems, as seen in Chapter Five.

PART B : INTERVIEWS WITH G.P.'s

1. Explanatory frameworks

1.1 Causation, the individual, their circumstances and the illness of depression

1.1.1 Situation and circumstances or individual biology

Within the interviews with G.P.'s, there was a distinction between depression which could be explained in terms of the individual's circumstances and depression which was seen in terms of a problem located in the individual and as biological. These were distinguished as two types of depression, reactive and endogenous depression respectively. This distinction was referred to by psychiatrists in their interviews, but not as a distinction which they used in practice.

Dr.B: Well, yes, I think there is such a thing as depression. I think I would define it as a mood, an affect which is inappropriate to the immediate circumstances in which a patient, person finds themselves. So that, um, it continues beyond the event which causes it. Not sure that's a very good definition, but anyhow let's leave it at that.

Siân: So is that, um.

Dr.B: Well, I mean, one point is that it's a reactive and endogenous depression. A reactive depression is understandable in terms of something which has happened to someone such as a bereavement, whereas endogenous depression isn't.

However, it is unclear whether depression which can be explained in terms of individual circumstances is a medical problem or condition, or not. For example, there is the suggestion that depression is a reaction which is inappropriate to the circumstances, and later reactive depression is distinguished as that which is explicable in terms of an individual's circumstances.

It is clear that endogenous depression is that which cannot be explained in terms of the individual's circumstances. It is explicable in terms of individual biological dysfunction, in the absence of any other explanation.

Dr. T: We certainly see a lot of patients with depressive illnesses, much more so here than most areas, I think just because we're dealing with a lot of people who have circumstances that would make any of us depressed. I think, yes we do, we certainly, we have endogenous patients: patients with endogenous depression who are just depressed for no good reason, but a lot of the homeless people we're dealing with and the single Mums and these people in financial straits have a lot of depressive illness. I think it's largely because they have no way of improving their lot. They can't actually by doing anything different improve their status or their situation. They're in grotty accommodation and they've got everything stacked against them.

Depressive illness covers both depression explicable in terms of individual circumstances and depression which is explained in terms of individual biological malfunction, characterised as reactive and endogenous depression. This can be related to the analysis of the patients' interviews (Chapter Five), where explanatory frameworks related experiences of depression to individuals' situations and alternatively, or when this failed, depression was seen as indicating a problem in the individual (Chapter Five, Part II, Part C).

1.1.2 Causation

Depression has social and biological causes. It may be related to individuals' circumstances and their reactions to them over a long period of time.

- Siân So do you see that as being social causes of depression, not necessarily biological?
- Dr.T Yes. Yes, that's right, yes. I mean there's quite a lot of patients who have all the social causes stacked up and sail through very happily and either have a benign, either irresponsible attitude towards it, or work out some... strategies, but there's a lot of people who are squashed down and it isn't usually that they've been in that situation for a few weeks. It's obviously been either like that from as long as they can remember, or that they've dropped down the pile somewhere or other and have been knocked down as a result of that.

Depression has many causes, and can be explained and distinguished in terms of causes lying in the individual's circumstances, as either reactive or endogenous depression. Reactive depression is understood within a framework of individual circumstances. Endogenous depression is understood in terms of having biological causes and is distinguished from reactive depressions on the basis of this.

- Siân: Do you think there could also be biological causes there?
- Dr.T. Yes, quite sure, but again, I don't think every depressive illness has a biological cause either. There's no question that the endogenous depression has a biological cause, post-menopausal depression which can be one of the miserable intractable ones is proven to be of a biological basis.

Another G.P. rejected the classification of depression as reactive or endogenous, because she saw the problem of depression as a spectrum and as more complex. She emphasised that depression is complex with many causes and thus cannot be distinguished as either reactive or endogenous. She argued that the impossibility of defining depression in terms of its causes meant that the standard medical definitions of reactive and endogenous depression were unacceptable to her.

Dr.G: I am reluctant to define it in classical medical terms, because I understand them to have defined it in two ways - as a neurotic depression and as an endogenous depression - and I don't think that's satisfactory. I would see depression as a spectrum, going from feeling sad to being severely depressed and with psycho-motor retardation and all the, kind of, physical so called endogenous symptoms. And I'd see that all as a spectrum, and that you just get more and more severe the further down that spectrum you go. So I would call that depression - from kind of, sadness and unhappiness down the way to being unable to move or speak or, you know, committing suicide... So I try and avoid standard definitions because, for me, it's a bit of a mish mash in a spectrum that has many causes and I accept them all. I'm a catholic!

1.2. Endogenous depression: real depression is biological.

Endogenous depression may be used to distinguish depression as a recognised medical problem from unhappiness. Endogenous depression is identified in terms of symptoms, in particular physical symptoms. It is suggested that individuals should refer for medical treatment when depression is becoming endogenous. This implies that depression becomes a real problem when it is distinguished as endogenous depression, when it is biological and when it manifest itself in terms of physical symptoms. It is implied that endogenous depression is distinguished from reactive depression, because in endogenous depression individuals are unable to react to changes in circumstances.

Siân: So, how would you distinguish between somebody who is maybe living in very difficult circumstances or was very unhappy for whatever reason, and that unhappiness and depression.

Dr.B: I think unhappiness is, er, I think, obviously they splurge into each other, but people can be unhappy, very unhappy, but still function in a way which means that their mood can change, they don't have, the sort of classic example, the classic symptoms of endogenous depression such as sleep disturbance, appetite disturbance.

Siân: And at what point should people refer themselves for treatment? Or go for help?

Dr.B: I think when, um, when it's becoming endogenous. That's a useful distinction if you like. Er, when it is manifesting itself in sleep disturbance and not being able to enjoy anything. People can be very unhappy, from circumstances, and still get a kick out of meeting friends or seeing something funny on the television, or reading a book, OK, it doesn't mean to say the sort of substrate of their lives isn't profoundly unhappy.

This is a tautologous basis of definition. Endogenous depression is identified in terms of physical symptoms. But it is explained in terms of the absence of circumstances which might account for depression, and in terms of the inability of the individual to react to changes in their circumstances. Reactive depression, with the implication that physical symptoms are not so pronounced, is explained in terms of the individual's reaction to circumstances. But it is also suggested that an individual's life might still be

profoundly unhappy and that the distinction between unhappiness and depression lies in their ability to react to changes in circumstances, to be reactive.

It is implied that the serious problem of depression is endogenous depression and that this is located in the individual. Classic endogenous depression is defined in terms of physical symptoms, as something which is uniform across persons. But it is also suggested that the circumstances of depression are individual. It appears that endogenous depression is a distinct state which exists independent of circumstances, but that it can also be understood in terms of the personal circumstances surrounding it. There is a contradiction within the definition, which suggests that the distinction between endogenous and reactive depression is unclear. But whereas reactive depression is understood in terms of the individual's circumstances, endogenous depression is identified through physical symptoms.

1.3. Illness and the individual: Depression as an illness: containing the problem.

Depression is identified as an illness and this is understood in terms of the distressing nature of the experience, its abnormality and its treatability. The understanding of depression as an illness is significant within a moral framework, since it absolves the individual from blame, responsibility and accountability. It is understood as distinguishing the problem of depression from the self, as containing it and as limiting the individual's role and responsibilities. It is suggested that the idea of depression as an illness is liberating, and this is consistent with the theme within the analysis of the patients' interviews, that the diagnosis is potentially liberating.

Siân: Right. Um, would you see it as an illness?

Dr.B: I think it's an illness in the sense that it is something which is distressing for people, it's something which is abnormal in that it can be distinguished from what would be normal, and also something that can be treated, yeah.

Siân: In some ways is the illness distinction not very helpful or not very relevant?

Dr.B.: Oh no, I think it is relevant. Yes, it's relevant because if you say it isn't an illness, the implication of something not being an illness is tied up with accountability and blame. And that's important for people. But if you say, well it's not really illness, it's how I am, then people immediately take the blame on themselves, whereas if you say it is an illness, for better or worse, it's something which happens to people, and I think that, certainly for endogenous depression, is a more helpful way for everybody, of looking at it.

The idea of an illness may also be used to remove the stigma of depression, because as a recognised illness it is analogous to physical illness and so cannot be seen in terms of individual blame or accountability. However, one problem in treating depression is that as a medical problem it is seen by patients as stigmatising.

Dr.T: I think it's [depressive illness] a fact of life. Certainly the idea of pushing it completely under the carpet doesn't wash. That's where people facing up to things and also - I've spent quite a lot of time trying to get into people's heads - it isn't a stigma. If they came to me with gall bladder pain that isn't a stigma. If people come with a depressive illness it isn't their fault that they've got a depressive illness, or if there has been any sort of cause way back it isn't that they are to blame for that. They need to be able to come and we're just as keen to be sorting this out as coughs and colds and things like that.

2. The treatment of depression.

2.1 Pragmatism

It is suggested that treatment for depression is on a pragmatic and empirical basis, rather than based on abstract definitions of the problem. Within this framework, depression is seen as complex and as the result of a number of problems, rather than as a clearly definable problem to which there is a known solution. One G.P. described himself as finding stop-gap treatment for the illness while other problems involved in the patient's depression were resolved on a longer-term basis. Thus, anti-depressants might be offered as the most readily available and fastest effective form of treatment, rather than as the solution to the underlying problem, in a conceptualisation of depression as caused by circumstances as well as in terms of individual biology.

Dr. T: Obviously the ones who have circumstantial problems that cause them to be depressed, if the circumstances can be changed then they sail ahead and the depressive illness usually simmers down very quickly. Where we can do a little to address the problems then we do. Usually we're after providing stop-gap treatment and that can be treating depressive illnesses while we are waiting for other things to get sorted out.

2.2. The treatment discourse

Depression may be defined in terms of the treatment available. Thus the availability of psychotropic drugs may have defined it as both a biochemical and as a medical problem. Concepts of depression can be seen to change as different treatments become available, and can be understood as social constructions.

Dr. B: Part of a discourse and the definition about depression has been redefined by psychotropic drugs. So, the fact that there are antidepressants has both, has to a certain extent defined depression. There's a tautology there. But one could almost say that depressions are moods which are likely to be helped by antidepressant drugs. Alright? And the second important consequence of that is that it medically defines depression because only doctors have access to these drugs.

This is illustrated further in an excerpt from another G.P., who suggested that depression must have a biochemical basis since drugs did have an effect.

Dr.T: There's no question that the endogenous depression has a biological cause, post-menopausal depression which can be one of the miserable intractable ones, is proven to be of a biological basis. I don't really know enough about the pharmacology of the medication. Obviously, it works on a chemical basis. If you give people anti-depressant tablets and they, they get better then there's got to be a chemical basis to that. It's not just the placebo effect.

2.3 Depression as a medical problem.

The G.P.'s role is seen as deciding on the most effective approach to the problem of depression, given a knowledge of the resources available. Depression may not necessarily be seen as a medical problem. Within a pragmatic approach, the role of the G.P. is seen as distinguishing whether or not it is a medical problem. Although depression may be understood in terms of depressive illness, it is also suggested that it might be resolved by changes in circumstances and that this does not fall within the remit of the G.P.

Related to this, it is suggested that depression itself cannot be clearly distinguished, since it covers a complex spectrum of experiences and illnesses. Whereas abstract definitions of depression as endogenous or reactive may be clear, these are not easily related to the complexity of experiences and variability of experiences between individuals. Treatment and approaches are then of necessity pragmatic. This echoes the approach of the psychiatrist Dr. K., that treatment is essentially empirical and pragmatic rather than scientific (see Part A, section 2.2, above).

Siân: So should it be necessarily seen as a medical problem?

Dr.T: I think it needs somebody to differentiate whether it is or not. That may sound a bit silly, but the message I'm trying to get across is that it isn't just that people have depression or they don't have depression. There's a whole spectrum of depressive illnesses from the ones that are more agitational or anxiety based through to, you know, right across a spectrum, and so it needs discernment to say whether a particular person is likely to need counselling help, is likely to need medication, is likely to need other sorts of approaches, or is likely to need circumstances to be put right. Now I think it probably does need somebody with some experience to weigh that. Anna, our C.P.N., could probably weigh those sort of things just as well as we could. The social workers can often pick up and address a lot of the circumstantial areas, but actually it takes time to do that. If we send someone to see a social worker then they don't have all the problems put right in a fortnight either. So people are waiting months till that's dealt with. If people come and see us and we feel it's appropriate we try antidepressants. Then it's reasonable to expect that if they're going to do something they'll have done it within a month and so I think probably people are going to get sorted out quicker that way than if they try pushing open all the other doors. So, although it doesn't sound particularly scientific to say that we almost treat people on a 'suck it and see' basis, that we try medication if we feel that's appropriate.

2.4. The role of the G.P. within the medical process.

The role of the G.P. within the medical process may be characterised as the gatekeeper to a variety of resources, and even as diverting the patient from a purely medical approach. Here, the G.P. is seen as following a bureaucratic function within the medical process, rather than as following a purely scientific model of depression as a biological problem. The role of the G.P. is to deal with the complexity of issues and of potential causes, including the biological, the social and the psychological, which are involved in depression. One problem, identified below, is the limited resources available to G.P.'s to treat depression, which are alternative to drug therapy.

Siân: Yes. So, like, if it was an ideal world, who would be the best help, professionals to deal with it? Would it be GP's or - ?

Dr.G: Depression?

Siân: Mmmm.

Dr.G: I think that good G.P.'s plus their back up teams are probably, you know, like with resources to other kinds of therapists - . Like, if we had full resources then, you know, we'd have a counsellor who had lots of appointments and an art therapist who would see young people as well, and um, I mean, we do run group - like our counsellor runs a group, or two groups I think - so I mean, if we had endless resources, then we'd provide for different, for different sorts of therapists. And that people who wanted to have more in-depth psychotherapy, you know, could afford to.

Siân: Yes.

Dr.G: So I think that G.P.'s probably would be the best bet. Because they're our, kind of, central person who could, you know, divert people and say, "Well look, this sounds like you would be better off here".

The position of the G.P. in deciding the appropriateness of treatment is based on their expertise in prescribing medication where appropriate. As suggested above, the availability of medication is powerful in defining depression as a medical problem. Since doctors alone have the power to prescribe medication, in practice only doctors are able to decide appropriate treatment for depression, and on this basis it is assumed by doctors that they have particular expertise in dealing with depression.

Siân: Would you think that the G.P. should be the front line people to deal with it [depression]? Or, if you could do anything, would you change that?

Dr.T: I think it has to be, in that G.P.'s have traditionally acted as gatekeeper and people come to us and we need to be deciding where we - we're a sort of sorting agency. We decide where people go... Again, I have no wish at all to empire build or keep control in G.P.'s' hands that could be dealt with elsewhere, but I don't think it's unreasonable to say that our several years of training has put in a better position to be able to delineate the people who just need a bit of encouragement from the ones who need medication, from the ones who need secondary referral, and so on. Our difficulty as G.P.'s is that we may well want to go for the full works with all the patients who come to us with depressive illnesses and there just isn't time.

An alternative and contradictory conceptualisation is that the G.P. is an appropriate person to deal with depression because he or she is located within the community. This suggests that they are appropriate in comparison to other medical specialities. However, the claim that G.P.'s are appropriate people to treat depression rests on their place and expertise within the community as medically trained specialists. Below, there is a contradiction within a claim for G.P.'s to act as gatekeepers for treating depression. This claim rests both on G.P.'s medical expertise and on their position within the community, but their expertise is only medical, and they are not specialists in the community, while the conceptualisation of depression as a medical problem is also rejected.

Dr.G: But having said that, in an ideal world, I don't really think that doctors are the best people to deal with what we term mental illness anyway. This is not standard medical view. I don't really believe in medicalisation of what are called 'mental health problems', because I don't think that they're medical problems.

Siân: Right.

Dr.G: You know, although I admit that there is often a physical element and I don't mind dealing with that physical element, I think the other element is far better suited to other people and, you know, in an ideal world, there would be a group of people who were trained in, people whose minds weren't working to their satisfaction.

Siân: Yes.

Dr.G: Or to the tolerance of their neighbours. And I don't want to sort of, I mean, I think to, kind of, label it any more immediately brings it into our domain and I think it should be out of our domain and that people in the community should be working with those people who are out of synch'.

Siân: Yes.

Dr.G: But it isn't, it is medicalised, so if it's going to be medicalised then I think the best person to deal with it is the G.P. Because at least they're in the community and, on the whole, a lot of them don't medicalise it and recognise it as part of a thing that goes on in the community and can be dealt with in the community. Do you know what I mean?

3. Summary

Depression is related to individuals' circumstances. Despite the apparent clarity of definitions of depression as endogenous and reactive, used by G.P.'s, these definitions are tautologous and may be inadequate. It is not clear if they are alternative classifications, and whether they are classifications based on causation or severity. Depression is understood within the terms of the individual's circumstances or, and maybe failing this, as a problem within the individual, and these understandings are not exclusive of each other, though they may be contradictory.

The emphasis on problems in the individual or their social circumstances is similar to the explanatory frameworks used by psychiatric out-patients interviewed in Study II (see Chapter Five, Part II, Part C). Unlike for psychiatrists, depression is very much related to an understanding of individual circumstances. There is no clearly defined

definition of psychiatric or mental illness as a professional or specialist construct. More than for psychiatrists, depression is understood more in terms of individuals' lives and less in terms of a specialist medical model.

In terms of approaches to treatment, the first problem is seen as being to establish whether or not depression is a medical problem. The G.P.'s function is also seen as pragmatic, in directing the patient to the most appropriate treatment, given what is available and the time span of effectiveness. However, available treatment is also seen as defining depression; notably, the availability of drug therapy defines it as a biochemical and medical problem. This legitimises G.P.'s as the most appropriate people to deal with depression, since they provide access to drug therapy and are also located within the community with access to alternative resources. There is an implicit contradiction here, since it is not clear that depression is a medical problem, and if it is not are G.P.'s the appropriate people with appropriate training to deal with it? The power of doctors in dealing with depression may rest on their ability to prescribe psychotropic drugs.

The medical process and medical definitions of depression may provide a pragmatic approach to management and control, rather than resolution, of depression. The responsibilities of G.P.'s include diversion to other sources of help rather than only treating depression as a medical problem. There is a contrast between pragmatic approaches to treatment and the clarity of definitions of depression, as endogenous or reactive. It is at the least very doubtful whether formal medical knowledge relates to the complexity of subjective experiences of depression.

PART C : INTERVIEWS WITH CLINICAL PSYCHOLOGISTS

Clinical psychologists interviewed about depression demonstrated distinct understandings of depression, which stood in contrast to the medical model and constituted a contradiction and rejection of that model. They saw themselves as having a distinct role in treating depression and in helping patients. But they also suggested that, working within the health service, they were in fact restricted by the terms of the medical model, which predominated in health care, which defined their functions, and on the basis of which they were accountable. This restricted their freedom to work in alternative ways to those consistent with the medical model with depressed clients. For some clinical psychologists this presented greater problems than for others. Clinical psychologists interviewed suggested a tension between their own beliefs about depression and the restrictions within which they worked in the National Health Service. In the National Health Service, a medical model predominated and work was on an individual basis with little opportunity to look at social issues.

The analysis that follows is organised around themes which highlight the dilemmas faced by clinical psychologists as they reject the medical model, seek to offer alternative approaches, and negotiate their roles in relationship to a predominant understanding, within the National Health Service, of depression as a medical problem. It will be shown that clinical psychologists rejected the medical model as the basis of an understanding of depression. However, there was no available alternative and acceptable discourse of depression, within the organisation of health care, which did not buy into this model.

The clinical psychologists interviewed, however, did see themselves as working in alternative ways to that of the medical approach to treatment, and emphasised notions of personal growth and development. They focused on individual experiences of depression and the meaning of those experiences to the individual, and were aware of the importance of social issues external to the individual in shaping the individual's experiences.

One problem was that the limit of clinical psychologists' professional practice was a focus on the individual, with a neglect of the environment. This presented a dilemma for one clinical psychologist, who focused on the importance of environmental factors in her understanding of depression. The predominance of the medical model was identified as a growing problem within the practice of health care, as reorganisation was seen to restrict practice and terms of accountability to within the medical model. The organisational constraints placed on clinical psychologists within their practice in the

health service can be seen to place them in contradictory positions, given their own understandings and beliefs about depression.

1. Rejection of the medical model.

While clinical psychologists interviewed accepted the notion of depression, they offered a distinct understanding of what depression is, from that presented within the medical model, where depression is seen as an illness and is categorically defined. Clinical psychologists interviewed understood depression in terms of the individual's life, as a meaningful experience and as a dynamic rather than a static experience.

More specifically, clinical psychologists rejected the idea that depression could be explained in terms of its biological components, or that biology is an adequate approach to depression, which was how they understood the medical model. They considered that psychological components were neglected within the medical model, but that the medical model was nevertheless very powerful in approaches to understanding depression and to practice.

Hilary: I do believe that there is such a thing as depression, but I'm very unhappy with this idea that it's an illness really. I think it does have biological components but I think too often they're concentrated on to the neglect of the psychological components. And I feel that that reflects the general prevalence still of the medical model, and in fact that many difficulties that people have in their interpersonal lives are very much viewed in the illness model as opposed to in a kind of process model, which is how I tend to approach things.

Depression was understood in terms of a feeling rather than as a clear category. It is a feeling that can be recognised, but not necessarily a thing which can be clearly defined. The notion that depression can be understood in medical terms and categorised as a medical problem is seen as simplifying the problem, and removing it from its connection with more difficult issues. Depression is not a clear problem which can be contained and treated. The notion of treatment is rejected and it is suggested that depression is extremely complex, that it is not something which can be treated and removed.

Siân: I suppose the first thing is whether you think there is such a thing as depression?

Allie: Um, yes. I think it depends how you define it... I mean, I don't really, I don't really like the medical - I think here because of the way that the, that um, kind of particularly British western society is structured it's a very medical concept, um, and I don't really like that as a, kind of, concept. Um, and I don't actually find it - personally, I don't actually find it that useful because that just, kind of, means that you treat and I think that a lot of the roots of depression are elsewhere in much more difficult, kind of issues rather than - you know? Somehow it sanitises it

I guess. But, yes, I do believe people sort of get depressed - that's used in a very, very broad sense but er, um, there is something that I understand as depression that I could meet people and think, "Yes, they are feeling this way. They are depressed." But I don't like the category that has, that we've come to understand it as.

A clinical psychologist who had worked as a psychiatric nurse before training in clinical psychology argued that his understanding of depression and hence his notion of how to help people had radically changed as he changed profession. Thus, within the medical approach of psychiatric nursing depression is seen in terms of symptoms, and treatment is directed to removal of those symptoms or, as he also suggested elsewhere, control and management of the patient. In clinical psychology, he viewed depression as an experience with meaning for the person, in an approach which went beyond looking at symptoms, and which suggested that depression was an on-going and dynamic experience, rather than a state or category. In this approach, working with a depressed person involved enabling them to "move" or to develop their experience. Here, the emphasis is on experience and meaning for the individual, rather than on the notion of depression as an objective problem defined in terms of objective symptoms.

- Siân: Yes. Does your understanding of, did you do the psychiatric nursing before psychology then?
- Rob: Before clinical psychology. After my psychology degree and then before my clinical psychology degree. After five years psychiatric nursing.
- Siân: Oh, right. So has your understanding of depression changed a lot through doing clinical psychology?
- Rob: Yes. Oh, my whole, not just my, yes, my feeling on depression certainly has, but also my notion of, of helping people has as well. Er, yes.
- Siân: In what sort of way?
- Rob: Well depression's moved, as I said before, from being the illness symptoms to be got rid of to experience which is real and which has a lot of meaning for people.
- Siân: Yes.
- Rob: And the role as a helper has changed from getting rid of those things to helping the person move.

2. Alternative models of depression

Clinical psychologists interviewed argued that there was pressure to use the language of the medical model within the organisation of health care in order to maintain professional validity as well as to communicate effectively. This suggests that clinical psychologists were unable, or were insufficiently powerful within the health system, to formulate an alternative discourse.

- Hilary: Though, so I'm not sure how useful it [DSM-III-R] is but I think in general that kind of medical categorising is here to stay and it's up to clinicians to work that framework as much as possible, because if you lose contact with how most other clinicians are thinking, like I work

within a multi-disciplinary team here and if I was going around being all airy fairy then my colleagues would dismiss me as useless.

In formulating an alternative discourse the emphasis may be on understanding depression as the experience of a person, and so describing the client's problems, for example in a referral letter, in terms which will be meaningful to that person. However, there are severe constraints on the language available to describe patients' problems within the health service, and there is an inescapable pressure to use medically based language. It is not clear that it is possible to construct an alternative discourse or to formulate an alternative understanding of depression.

- Siân: Yes. Is there quite a lot of organisational pressure then to use labels like "depression"?
- Allie: Absolutely. Yes. Oh yes. I mean, you can't get away from it. You cannot get away from it. And I use them. I will write to, I mean, I try not to - I have this, kind of, if I'm writing to G.P.'s or psychiatrists and that I try not to use, I try to use, I basically try to write a letter so that if I was the person concerned I'd like to read it. Um, well not like to read it but feel OK about reading it, um, and I try not to kind of use, you know, "This person is severely depressed and de, de, de." Um, and I mean, it's just a kind of little thing but I'll probably put something like you know, "This person experiences feelings of low mood de, de, de, de, de, de." So it's an experience not that "This person is sick".

Medical labels are problematic because they convey specific conceptualisations of depression and are directed towards a particular mode of treatment, management and control, which the clinical psychologist here rejects as antithetical to her understandings. Therefore the pressure to identify problems in terms of medical language is one which she resists. She understands experiences as meaningful to the person rather than as labels and categories which are objectively identified as external to the person.

- Siân: And all those different categories, you know, like depression and difficult behaviour or whatever, are they actually very meaningful at all?
- Allie: No. They're only, well yes they're only meaningful in terms of social control. They're only meaningful in terms of um, in terms of managing that person.
- Siân: Right.
- Allie: So I don't think it's any, I don't think it's any mistake at all or any, kind of, coincidence that in, say, learning disabilities you have all these behavioural definitions of problems... But it's all in an external, it's kind of an external construct... So it's people from the outside saying, "Well this person - ", and basically what it boils down to is "This person's a pain in the arse"... So the way it comes to me as a psychologist is that these are the labels that people come in with.

In particular, the use of medical language is related to issues of management and control through medication rather than understanding the problems in terms of the patients' subjective experiences. In using such medical language in identifying problems the clinical psychologist may be inadvertently supporting a medical approach. However, at the same time it is not clear that there is any alternative language available which has meaning within the organisation of health care.

Allie: Now I can think of one particular example recently of somebody, a woman who was referred to me, and the question from the psychiatrist was, or from the team, from the psychiatrist, was, um, "Does this person have sexual problems?"

Siân: Yes.

Allie: Now I knew immediately that's the sort of, it's all like the kind of institutional, kind of coded language, and I knew immediately that that meant, um, "Please can you tell us whether you think this person has a sexual problem or doesn't". Er, "And then based on that analysis we will either give", you know, "Give x drugs or won't.

Moreover the medical model is seen as increasingly powerful within the organisation of health care, leading to an increasing emphasis on drug treatment. Ultimately this leads to a greater marginalisation of clinical psychological approaches to depression. There will also be less choice available of therapies, alternative to drug based therapies, in order to meet patients' needs.

Rob: I think the predominant, if you're a sufferer from a depressed experience and you present for services, you're chances of being met with one particular model imposed upon you will be far greater.

Siân: Yes.

Rob: Than they have been in the past. And that model will be of a medical illness, underlying cure, problems, and the drug will probably help you - and if it doesn't help you well, we'll just find the one that does because they're are lots of them around. Don't worry you'll feel better. And don't forget, it'll go in six months time anyway.

3. The roles of clinical psychologists within the health service.

Consistent with their rejection of the medical model, clinical psychologists interviewed did not see themselves as "treating" depression, which carries with it the idea of an illness. Clinical psychologists saw themselves as helping in different ways. There was a theme of helping the person to move through depression, in a dynamic and experientially based approach. However, this did not necessarily deny the notion that depression was a thing, an entity, and that it can be got rid of. It was not always clear how the role of a clinical psychologist could be characterised in an alternative approach to that of the treatment model, although the notion of treatment was rejected.

- Siân: Do you think you can cure depression or just help people to cope with it?
 Hilary: Well, cure implies a medical model so I'm not happy with that really. But yes, I think it can go away. Either through antidepressants or through changes in life circumstances or through how a person perceives things or whatever, certainly.

A clinical psychological understanding identified in this excerpt is of depression as the experience of a person, as a dynamic experience. Within this approach, the person could be seen as active, and the role of a clinical psychologist as a facilitator, enabling the person to move, rather than acting upon them in providing a cure. This is distinguished from a clinical psychologist's earlier experience of work as a psychiatric nurse, where the emphasis was on getting rid of symptoms within a medical model:

- Rob: And the role as a helper has changed from getting rid of those things to helping the person move.

The notion of treatment is rejected, since it implies that depression is something to be got rid of, as in a medical model of symptoms and disease. From an alternative perspective, depression may be seen as functional and as personally meaningful, in particular indicating a need for personal change. From this perspective, the role of the clinical psychologist is as a partner or facilitator in the process of change, providing support rather than solutions, in relationship with the client and addressing the needs of the individual client.

- Siân: So how would you go about helping? Would you think of your work as treating somebody with depression or - ?
 Allie: Um, I don't like the word treatment really 'cos, I don't know, maybe it's just kind of linguistics but um, yeah, I mean, I'm in a job that is supposed to treat depression. Um, or treat these mental health problems but I don't like the, I don't, I don't believe that I do treat. I believe that people, I know it's totally bizarre, but my understanding is that people come to seek help through our service or various other services, but particularly when it comes to me, seek help, um, because they are, they need to change in some way. So if somebody comes feeling depressed, and it's usually, I mean, that's very common to a lot of different things that you work with, is this thing 'depression'.
 Siân: Yes.
 Allie: Um, and my, and then I guess I wouldn't, I would never, sort of, presume that it could be treated. Um, but I mean, in part of my work would be to try - what I would try and do is actually form some kind of alliance. That's actually, um, and I guess, almost, like I see it as sort of, as sort of like a journey, going on a journey with somebody.

The approach of the clinical psychologist here is to focus on issues of individual meaning. This is distinguished from the medical approach, since it involves looking beyond the label, and formulating a social or psychological understanding rather than working within a biological model. Thus the focus is on depression as the subjective

experience of a person rather than on generalisations about experiences across individuals. The approach is individually centred. However, this incorporates and does not exclude consideration of social factors.

Allie: I mean, I think you're in a different culture but you're not in a medical culture that accepts the idea of disease or, you know, whatever it is-

Siân: Yes-

Allie: Biological roots. Because you do have more of a social or, yeah, I mean, it has to be social or psychological understanding. Therefore you just ask different questions and it doesn't mean to say they're any more right or wrong. But you ask different ones. And that can help. So I think, in terms of when people come and they've got these labels, whatever it is, they come for depression or anxiety. I think anxiety is very linked to depression. Um, you can, you can do a service just by trying to establish what it is, what it means, what it means for that person. So in that extent, it's highly individualistic but it might, it, you know, it might be a whole set of social circumstances, but it's highly individual for that person.

The role of the clinical psychologist was distinguished from a medical approach and presented as an alternative to that approach. However, while clinical psychology may be presented as alternative to the medical system it is not clear that it has a distinct role and approach which is validated within the organisation of health care. This may be related to the position of clinical psychology within the organisation of health care, since within the organisation of the health system the medical model, which clinical psychologists interviewed criticised, is dominant.

Rob: Is clinical psychology in there? It's a hugely difficult position... Er, I think it leaves, psychologists are seen by those who are in power, very much on the outskirts. A luxury thing or, you know, the bad boys and girls who, who niggling at mum's and dad's, sort of, heels, you know. And that's what it feels like sometimes, that we can be tolerated.

4. The profession and practice of clinical psychology.

It is not clear that there is a coherent model of depression which is distinctive to clinical psychology nor, more generally, that clinical psychology has a distinct and coherent professional identity within the health service. Contradictions emerged as clinical psychologists interviewed described their understandings and approaches to depression, and their experiences of training and professional practice. Their work within the health service was concerned with the treatment of individuals, structured according to the medical model which saw the problem of depression as located within the individual. At the same time as they themselves recognised the importance of environmental and social factors in depression, the structure of their work within the health service constrained them to working only with individuals.

This is seen as a problem of working within a predominantly medical system, where depression is structured as a medical problem to be resolved by treatment of the individual. The predominance of the medical model means that difficult questions about social issues may be avoided, since the problem of depression is instead constructed at the level of individual pathology. Given the predominance of the medical model in explaining depression, the possible implication that the prevalence of depression indicates problems at a social level is ignored. There is little appropriate help available for treating depression as a social problem.

Allie: Um, and I think, and that, I believe in depression, it is functional. You know, it is functional to be depressed if you're in some circumstances. And the way that we have evolved to deal with it is in a, kind of, quite a medical sense. Which then means that we don't have to, we don't have a lot of, you know, we don't have to, we can say... we're doing something about it because, you know, you can see a doctor and, you know, you've got this kind of medical system that you can go into. Rather than actually fundamentally thinking, well, maybe we're living in the wrong way... Are we, are we addressing these things at a group level, at a social level?

Clinical psychologists interviewed argued that in their work they are mainly constrained to working with individuals and, although they may acknowledge the importance of social influences, the effective boundary on their work is that they work mainly with individuals. (They may however also work with groups and families, but here the emphasis may still be on individuals within the group, rather than on wider social issues.) One psychologist believed that this had to be acknowledged in work with the client.

Siân: How does that affect, right, if you think the environment's important, so how does that affect your treatment of somebody in depression? And how are you constrained by this, sort of, need for clinical psychology to work in the individual model?

Rob: Absolutely. Er, I'm, I have no way into any social intervention at all... I cannot, that's a boundary condition which comes over in the first couple of sessions and I have to tell them.

This presents a problem for individual clinical psychologists, who may understand social and environmentally based models of depression as alternative to mainstream clinical psychology and as problematic given the structure of their work within the health service. One psychologist interviewed believed that ultimately she would be unable to resolve this dilemma or to continue working within the health service. The contradiction between her belief that depression is a social problem and her role in working with individuals was embodied in her practice. While individual therapy may be understood as an effective means of empowering the individual, it may also be

understood as a palliative which reinforces the construction of depression as a problem contained within the individual. The discrete categorisation of problems as depression and individuals as suffering from such problems may be a way of avoiding underlying social issues. Individually based treatment is problematic since it may divert attention away from social issues.

- Siân: Mmmmm. Is it difficult to work like that as part of the Health Service?
 Allie: Yes. Very difficult. I mean, the way that, yes, I mean, I'm always in a continual like, I kind of shouldn't be doing this really. I shouldn't be doing um, the sort of therapy. I'm very, very sceptical about therapy or, um, no, that's not true. I have a kind of split relationship with it. Part of me thinks that it can be really, really useful and I really believe in it - in a certain way, you know? It's like, this is what I believe in, and there's all that and there's this much that I believe in -
- Siân: Yes.
 Allie: And then the other part of me thinks, "No, this is a waste of time or this isn't where it's at". So it's like a balancing act always between the two. And I think, at the times when I'm feeling optimistic and at the times when I believe in therapy, what I like about doing therapy and what I have experienced of having therapy myself, was that it can empower... Um, but the other side of it is feeling, well if I do, you know, if I'm-, just, it's just the individualistic bit, that's what gets me. It's just dealing with individuals and being involved in a system that only looks at treating individuals or special groups. You know, say you have a depression group or you have a whatever group, there's kind of discreet groups which goes along with this whole thing of, of reductionism really. Of sort of, putting things in boxes... But then, yeah at the back of it there's always this question of, you know, well, you know, are you just making things, like, is it just a sticky plaster? Or is it just some, you know, taking away the, kind of, irritation and what's going to happen? You know, the sort of, there is the social, social argument and I think ultimately um, working in the health service, I think ultimately I'm not going to survive because it bugs me too much.

However, depression is experienced as an individualised problem and individuals themselves do need help in dealing and living with their experiences. Individual therapy may be useful to clients and in providing it clinical psychologists may see themselves as working effectively, even within the constraints imposed on them to work within an individual model.

- Rob: Er, I'm, I have no way into any social intervention at all... Er, and some people will take that and say, "Oh, that's fine, you can't help me", and disappear. And that's fine. All I can work on is the kind of individual construe', re-construing process.
- Siân: Yes.
 Rob: I'm not going to be glib and say that er, no matter what the situation is, what you make sense of it is important. I know you've heard all those things in individual text books and in individual therapy already, and I think that only goes some of the way. But sometimes, some of what happens in the re-construing in the individual therapy session er, can produce their making changes in their lives.

One question which emerged was how flexible the profession and practice of clinical psychology might be. Allie, working within alternative models, saw herself as attempting to change the profession from within. Her role models did not emerge from mainstream clinical psychology. She believed that she was enabled to do this, at least to some extent, because there was a flexibility to individual practice. However, she saw herself as ultimately moving outside the health service.

Allie: Um, the role models that I have were, like, feminist psychotherapists or um, like, ideas with, not so much people, but ideas from, like, the White City Project - you know, social stuff. Or stuff like that, that was where my, kind of, orientation was... Because my, kind of, concept was, like, to bring these things from a different world, Tai Chi or whatever you want to call that world - complementary or whatever - to bring them into a very, kind of established system. And it was almost like revolution from within.

Another psychologist argued that clinical psychology was characterised by neglect of the environment. As a profession in practice and in the construction of clinical psychology's expertise, it is seen as heavily located within a medical approach.

Rob: Clinical psychology has developed always to not take account of the environment. It's got, it's had its roots very strongly in the medical model. And one of its boundary conditions, which, people talk about community psychology trying to break that boundary, but they're having enormous difficulty in, right now they're having enormous difficulties with... managers having to pay for that.

Thus while clinical psychologists may critique the medical model and attempt to construct alternative approaches and discourses, ultimately this is unlikely to succeed because the identity of their profession is embedded within the medical model. This contradiction is seen as contained within the profession itself, as well as imposed upon it from outside by the organisation of the health service.

Siân: Do you personally think that that's a boundary that should be moved beyond, that psychology should take more account of that?

Rob: I don't think clinical psychology can do it.

Siân: You don't?

Rob: No.

Siân: Why not?

Rob: Because it would dissolve the profession.

Siân: Right.

Rob: I haven't, I think things, like, clinical psychologists who may be can get off the treadmill of having to perform on the individual models which they're in now, which I'm in for instance, er, then it is incumbent upon them to point out the non-individual contributors to depression. Those who aren't, er, funded by those, by others who make them work on the individual model can really have quite an input.

The profession of clinical psychology is characterised by its relation to the health service and the predominance of the medical model. The medical model is so powerful within the health service that alternative approaches which emphasise social and environmental factors may only be suggested by individuals who are funded by alternative resources to the health service, and are outside the mainstream structure of the profession.

5. Accountability within the health service

Clinical psychologists are accountable to managers. Following the medical model, effectiveness is measured in terms of decrease of symptoms. This presents a dilemma for clinical psychologists who believe in accountability but who do not see measures of depression merely in terms of symptoms as providing an accurate measure of the person's state.

Hilary: I have to [use rating scales] in terms of justifying what I do and this again is contact-related. In terms of justifying what I do I'm under increasing pressure to provide data on people's severity of symptom levels, to be able to show that psychological interventions work, and that if someone's come with a BDI score of 39, then after 5 sessions it's dropped to 13 or whatever. So we have to be able to provide that to managers and I can see why, I don't think it's a bad thing in itself, but I do think that often the measures are very crude and quite stereotyped, and like any assessment measure is prone to variables, depending on which day you fill it in, or difficulties in your liability to whatever.

There is a contradiction or gap between how psychologists' work is assessed and their own aims and methods in working with clients. Standardised measures, on which accountability is based, are seen as providing a very general picture of the individual in terms of a medical categorisation. But this has little meaning from the clinical psychologists' perspective, given their methods of working and their understanding of the problems of their clients. Standardised measures are not seen as useful in practice but are imposed in order to measure accountability.

Allie: And we have a whole set of, kind of, standardised measures that I partake in because I, the reason I partake in them is because I believe in accountability. Um, but also, in terms of, like, giving you a very general picture of where that individual is in terms of population defined in this way. Um, but I guess it, it's kind of like, it's like saying it's schizophrenic, you know, what does that mean? It doesn't actually mean very much to me. It doesn't actually tell me anything about that person's life other than maybe they've got big problems, you know?

It was suggested that the emphasis in accountability is on the number of clients seen. This constrains or limits the time available for research. Ultimately, this may limit

psychologists to working within the terms of predominant models rather than researching alternative approaches and understandings and expanding the scientific basis of clinical psychology through questioning received methods. This may reinforce the predominance of the medical model within the profession of clinical psychology, since it is predominant within the organisation of health care.

Allie: [Clinical psychologists are] trained in science, some kind of enquiry, research - that, kind of, research orientation is very promoted within the profession. Although that is being very much undermined because of the, kind of, current changes. You know, it's, certainly for me, it's, you know, people are much more, the management's much more interested in, in um, knowing how many people I've seen rather than either the quality of having seen them or, you know, like they'd be much happier if I saw 30 people than, or 40 people or whatever, 50 people a week to get rid of their numbers rather than, you know, 10 people and, you know, some really good research or something. You know, it's not what they want to pay for. So you're hampered in that stand. But I think, the one thing that we do have to offer in mental health terms is that angle, is that we're not socialised in the same way almost.

Siân: Yes.

Allie: We're not in the same model, and that we do have a strong emphasis on actually, or should do, on asking questions. And researching into things and not taking the, kind of, givens.

Clinical psychologists may be prevented from developing alternative approaches, by organisational constraints and measures of accountability in terms of productivity (number of patients seen) and symptom reduction (in the use of quantitative measures of symptoms).

6. Summary

Interviews with clinical psychologists demonstrated how they were positioned as either rejecting or accepting the medical model of depression, and suggested a contradiction between their models of depression and the disease model on which the organisation of health care was based. The problems faced by clinical psychologists can be categorised under two overriding themes:

6.1. Organisational theme: the constraints of working in an organisation where there was a predominantly medical culture and where medical values were embodied in the terms of accountability.

6.2. Constructing an alternative to the medical discourse of depression: the difficulty of constructing a coherent model which was alternative to the medical model, and which represented a distinctly clinical psychological position.

6.1. Organisational theme

Clinical psychologists while rejecting the medical model were accountable in terms which did not reflect their own understandings of depression, and through which depression was constructed in terms of measurable symptoms. Their roles within the organisation of healthcare were constructed around a contradictory and ambivalent position: they were seen as presenting an alternative to medical care and they were constrained within an organisation based around the medical model. Clinical psychologists interviewed suggested that while they offered an alternative approach to the medical model they had no source of power or validation, and that they were constructed as both rebels and junior partners in the organisation of health care. The reforms and reorganisation of health care, and the increasing emphasis on numbers of patients seen, meant that there was less room for alternative models to the medical model within the organisation of health care, and that clinical psychologists were placed in an increasingly constrained position. This can be seen as a crisis of professional identity, focusing around the issue of how clinical psychology could present a coherent alternative to the medical model, moving from a position of simply rejecting the medical approach to presenting an alternative to the medical approach.

This analysis suggests that problems are faced by clinical psychologists working within the health service where a predominantly medical model of depression is employed, a model of depression contained within the individual and identified through symptoms, and where effectiveness of therapy is measured through the alleviation of symptoms.

Clinical psychologists may face a crisis, working within the increasingly tight limits of a reorganising health service, where accountability is increasingly based on the medical model. The crisis focuses around the identity of the profession, around defining the distinct role of clinical psychologists, either within the medical approach to the treatment of depression or in offering an alternative non-medical approach. It was also suggested that this may become an increasing problem, as other professionals such as nurses, who are cheaper to employ, are trained in counselling and psychotherapy, which will leave clinical psychologists vulnerable unless they can define their roles.

However, it is suggested that the problem is not merely one of defining a distinct role within the health service but a problem within the profession, since its roots are in the medical model while individual practitioners are increasingly aware of the inadequacy of this model. Individual practitioners practice flexibility in their methods of working, and their own understandings can be seen to develop as they gain experience. The question remains of whether clinical psychology as a profession will be able to contain such diversity, given its adherence to the medical model and given apparently

increasing organisational pressure to adhere to that model, at least in terms of accountability.

The dilemma for clinical psychologists may be that the approach to depression as the experience of a person, and as an experience on which individuals reflect and which has meaning, is marginalised within the organisation of health care where the medical model predominates. The problem may be better understood in terms of organisational power: the power of the medical system, and the prevalence of that system as the main form of help freely available, may be reflected in the prevalent discourse of depression as a clinical and medical problem.

6.2. Constructing an alternative to the medical discourse of depression

A further question emerging from this analysis is whether clinical psychologists do have a coherent alternative understanding of depression to the medical model. It was suggested in interviews that clinical psychology has traditionally ignored the role of the environment in depression, both in practice and in academic research. The brief review of the literature in this thesis (see Chapter One) suggested that depression has been approached within mainstream psychology as a clinical problem and that, adopting the emphasis of the medical model, depression has been understood as contained within the individual and identified in terms of symptoms. The analysis of interviews with clinical psychologists suggests that what may be needed is an alternative psychological approach which takes account of the environment and of the individual's inner world as experienced in relation to the environment. One psychologist interviewed suggested that the environment had been neglected within psychology as a whole:

Rob: And I was, I always remember being astonished at, er, going for my first degree, that everyone, the radical parties, political trainees, were wild about psychoanalysis. And the only thing that actually takes account of the importance of the external environment is actually Skinnerian stuff, and, can't explain stuff... but at least it looks at the personal relation to environment and says we can never know the inside story but we can know how the inside story interacts with the environment. And that's essentially a good thing which-, Skinner has always, in clinical psychology in England, been on the outside.

The question of whether clinical psychologists do have a coherent alternative understanding of depression to the medical model can be linked to the analysis of patients' accounts of depression in Study II (see Chapter Five). These patients were patients of psychiatrists or general practitioners and none had seen a clinical psychologist.

Firstly, the medical model is seen to be powerful in both the clinical psychologists' and patients' accounts. But within both sets of accounts there is dissatisfaction with the model and a tension between an emphasis on personal experiences as meaningful and the objective approach to depression as a medical problem.

Secondly, within both the patients' and the clinical psychologists' accounts the attempt to construct an alternative discourse of depression is problematic, since the notion of depression as a medical condition is powerful and in using the term depression there is an implicit clinical dimension. Thus for the patients the problem of depression was validated in medical terms in the diagnosis, and for the clinical psychologists depression is identified as a medical problem.

Thirdly, however, the emphasis within the clinical psychologists' interviews on the experience of depression as a dynamic, meaningful and variable experience is closer to the patients' accounts than the emphasis within interviews with psychiatrists and G.P.'s. In patients' accounts, explanatory frameworks of depression were identified in terms of an individual's circumstances and life experiences. In medical accounts, as seen in the interviews with psychiatrists and general practitioners, depression is understood in terms of an objectively identified and symptom based illness. The clinical psychologists emphasised the notion of depression as having meaning for the individual, in terms of the individual's daily life, and saw part of their work as the exploration and identification of that meaning.

Clinical psychologists interviewed conceptualised depression as the experience of a person, an experience which was dynamic and which was meaningful to the person. This conflicted with the terms of the medical model, where depression is constructed as disease. However, while clinical psychologists were clear in rejecting the medical model it was not clear that it was possible to form a coherent and consistent alternative position. In this respect, while clinical psychology might represent an alternative to the medical approach it is not clear what that alternative is.

This also indicates the pervasiveness and power of the medical discourse in defining depression. In using the term "depression" it is difficult to avoid the notion of a disease entity or medical implications. There is no alternative discourse available to describe a different or distinct approach. Clinical psychologists interviewed could be seen to be actively constructing an alternative discourse, which is based on the notion of depression as a meaningful experience to the person concerned and which is constructed in reference to a rejection of the medical model, but to be trapped within the terms of the medical model.

For example, one clinical psychologist, Allie, rejected the notion of treatment and reconstructed her role in terms of accompanying the depressed person on a journey, a dynamic notion which implicitly conceptualises the process of help giving as one of involvement in personal movement and development, not as a provider of answers.

Allie: Um, and my, and then I guess I wouldn't, I would never, sort of, presume that it could be treated. Um, but I mean, in part of, my work would be to try - what I would try and do is actually form some kind of alliance. That's actually, um, and I guess, almost, like I see it as sort of, as sort of, like a journey, going on a journey with somebody.

Similarly, Rob constructed his role as that of helping the person move, in contrast to his previous medical role as a psychiatric nurse where he had been concerned with the control of symptoms. Implicitly, depression is here seen not in terms of symptoms but in terms of a subjective experience of entrapment.

Rob: And the role as a helper has changed from getting rid of those things to helping the person move.

6.3 Concluding points

The two broad themes identified here as the provision of an alternative model and organisational constraints are of course linked, since it is partly as a result of their professional function that it is difficult for clinical psychologists to develop an alternative model. As in interviews with G.P.'s and psychiatrists, what emerges from the analysis is the predominance of organisational issues: processes of referral, accountability and treatment. The issue of professional territory is paramount: issues of who treats whom, and how, feed back into understandings of depression, which become, at least in part, an issue of professional status and accountability.

Whereas psychiatrists and general practitioners had clear categorisations of depression, which attempted to contain the problem of depression within professional diagnostic systems, clinical psychologists did not refer to diagnostic systems. Clinical psychologists took an experiential approach to depression as a subjective experience which was personally meaningful in terms of an individual's life. In being aware of the complexity of the problem they were enabled to reject the medical model. Clinical psychologists interviewed rejected the medical model, but were not enabled to suggest a distinct definition of depression by which they could redefine and control their own professional territory.

PART III DISCUSSION

This study was concerned to identify understandings and meanings of the term "depression" among groups of health professionals whose practice included the treatment of depression. This discussion will draw together points emerging from the analysis of interviews with psychiatrists, G.P.'s and clinical psychologists.

It should be emphasised that this is essentially an exploratory study. Some issues emerging, such as the importance of organisational processes, which are discussed here in relation to their implications for understanding depression, could be further developed as the focus of research, but that is outside the scope of this thesis.

No single basis for explaining depression has been identified. There is no single medical discourse surrounding depression. However, powerful themes have been identified within accounts.

1. An illness based approach to depression.

1.1 The notion of depression as an illness.

The notion that depression is an illness is powerful within accounts. It is supported within accounts of doctors and explicitly rejected within accounts of clinical psychologists. It is a powerful discourse in relation to which clinicians position themselves.

However, there is considerable variability between accounts, even where the notion of depression as an illness is accepted, in the implications of understanding depression as an illness. For example, is depression explicable in terms of an individual's circumstances, as suggested by one G.P., Dr.T., or is something defined as an illness because individuals perceive themselves to be ill, as in the account of one psychiatrist, Dr. P.?

Explaining depression as an illness and as a medical problem draws on related themes: the power of the bio-medical model and the treatment discourse of depression.

1.2. The bio-medical model.

The bio-medical model was powerful in the discourses both of G.P.'s and psychiatrists. But it can be used at different levels. The importance of a biological component may be recognised at the level of physical symptoms, at the level of a biological mechanism underlying those symptoms, or at the level of the underlying cause of depression itself. This is consistent with definitions of depression in terms of symptoms, as in the

identification of psychiatric syndromes, or in terms of causation, as in the application of a bio-medical model based on cause and effect.

1.3. A treatment discourse

Depression is also defined in terms of a treatment discourse, and this is based on the availability of treatments for symptoms of depression. It is an approach which is rooted in the biological approach, where depression is defined in terms of symptoms, and which also reinforces the argument for biological causation since symptoms are alleviated through biochemical treatment. But the definition of depression through the treatment discourse also defines it as a medical problem on the basis of organisational factors, for example who has access to what treatments. Thus as argued by one G.P., Dr.B., the availability of anti-depressant drugs could be seen to define depression as a biochemical problem, since these drugs were often effective in alleviating symptoms, and as a medical problem, since only medics can prescribe drugs.

2. Professional territories

While it is not clear that there is a clear, common definition or understanding of depression, there *is* considerable confusion over what depression is. Professional diagnostic codes were used by medical doctors to define depression as a medical problem within the terms of their speciality. As has already been discussed, this approach to depression as a medical problem and as defined using diagnostic codes was absent from the interviews with clinical psychologists. Clinical psychologists refrained from using such codes, except implicitly since they were treating people who had been diagnosed as depressed within the medical system, even if they were sceptical of the value of that system.

Professional diagnostic codes can be seen as an attempt to control confusion over the notion of depression, for example by psychiatrists redefining depression in terms of psychiatric illnesses. However, it has been demonstrated that these are used in different ways by different individuals. For example, psychiatrist Dr. D. explained her work in terms of psychiatric illnesses defined through diagnostic systems, as distinguished from depression, while psychiatrist Dr. P. rejected the relevance of such codes.

Diagnostic codes can be seen as marking out professional territory. The notion of illness serves to define depression as a medical problem, and diagnostic codes to further define it within terms of medical specialities. However, these codes do not relate to what individuals subjectively experience as depression.

It is notable that, in rejecting diagnostic codes, clinical psychologists focus on an alternative construction of depression as the subjective experience of a person as part of their life, and as meaningful to the individual. Their interpretation is much closer to that of the patients interviewed in Study II, (see Chapter Five), and in contrast to the psychiatrists' use of diagnostic codes is based on explaining depression as subjective experience rather than as an objectively defined pathology. Patients interviewed in Study II had not seen clinical psychologists, and so their accounts cannot be interpreted as influenced by clinical psychologists' discourses. However, it is not clear where clinical psychologists derived their discourses from: possibly from listening to their patients.

However, there is a real problem for clinical psychologists in that they are constrained in their professional functions, within an organisation where the medical model is central to and unifies the system. They position themselves as rejecting the medical model. But it is not clear what alternative understandings of depression they are basing their own work and professional identities upon.

3. The medical process.

There is contradiction between the medical discourses used in accounting for depression and the experiences of patients. This contradiction may be explicable through the predominance of the medical process.

The medical model is powerful within the medical process. Through the medical process, non-medical factors such as social experiences and social causes of depression are marginalised. Medicine is powerful, has claimed ownership of depression, and acts to define depression within medical terms.

There is a real dilemma for individuals who are working within the medical system, who are motivated to help the individuals who arrive in the medical process, but who doubt the efficacy of their professional knowledge or of the medical model in defining depression. The solution may be a pragmatic approach drawing on experience and personal skills as, for example, for psychiatrist Dr. K., who described the practice of psychiatry as an art, or it may be to seek to work as best possible within the limits of the system as, for example, in the case of G.P., Dr. T., who advocated treatment on a "suck it and see" basis. Alternatively, professionals may challenge the scientific basis of the medical model as in the case of psychiatrist Dr. P., who advocated the development of a coherent, non-biological model to replace the "myth of the biological model", or as in the case of clinical psychologist Allie, who rejected the medical model and saw depression in social and political terms as an experience of powerlessness. The practice

of G.P.'s who define depression as a community problem, while the legitimacy of their power to deal with depression within the community rests on their status as doctors, can illustrate a contradiction between the power of the medical model, and of the medical process, and the understanding of depression as a community and social problem.

The power of non-medical professionals to develop an autonomous approach to depression, which is free from the constraints of the medical model, is at issue here. While clinical psychologists may reject the medical model, their own legitimacy within the health care system and as a profession is dependent on terms of accountability which, it appears, are based on the medical model. There is a tension between autonomous professional identity and status and terms of accountability based on the medical model and the medical process, which is evident in the accounts of clinical psychologists.

The study of clinical psychologists' understandings of and approaches to depression demonstrated the power of the medical model and the difficulties of constructing an alternative approach. Clinical psychologists interviewed were aware of the importance of social factors and social experiences in depression. They were trapped within the medical model in terms of their practice and professional function. Clinical psychology is located within the medical process. While clinical psychologists may reject the medical model, at least in part, it is powerful in defining the culture of their organisations and this is reflected in the terms of their accountability and the limitations on their freedom to practice. It also legitimates their work with individuals in the medical system.

It is not clear what alternative approach to the medical approach clinical psychologists might adopt. They may not want to focus on a biological understanding of depression, but it is not clear that they wish to focus on an understanding of depression as a social problem either.

There is a broader conflict between the development of professional autonomy and the accountability of professions within the medical process. For example, G.P. counsellors interviewed advocated a non-medical approach to personal growth and health visitors advocated community development, but both worked with doctors and saw doctors as more powerful within the medical system in the treatment of depression, and either accepted patients from doctors or referred them to doctors. While both groups had specific expertise and claimed autonomy they were not treated with equal respect and did not have equal status nor autonomy within the health system in using their skills, in comparison to doctors. This led to contradictions in practice. For example, one G.P.

counsellor said that she had status equal to that of the doctors in her practice, and later said that the way she was regarded, as not being a doctor, was a problem for her. The development of autonomy for non-medical or nursing professions depends on distancing from the medical model, giving access to problems which are marginalised within medical organisations while retaining the authority and power which comes from working within the medical process.

Autonomy for professionals other than doctors is dependent on the development of an alternative basis of professional status to that of medicine. But such a development appears unlikely given the wider social factors: the power of the medical discourse in defining lay ideas and in particular the power of the medical process in defining the terms of bureaucratisation. While depression is defined within the medical process, there may be an increasing gap between this process and the needs of patients who experience depression in the context of social experiences and their everyday lives.

4. Concluding points

Depression is seen as a real problem when it is a medical problem, and this in turn reinforces and legitimises the role of the medical system in dealing with the problems of depression. This can be related to Anthony Giddens' theory of structuration (Giddens, 1979), (see Chapter Three, Part II, section 6). The medical discourse both reflects and reinforces the practice of medical institutions. This in turn may be related to an emphasis on the scientific and medical expert, whose knowledge shapes the social construction of problems such as depression as medical problems, and whose power is invested in the organisation of health care.

The primary focus of analysis and explanation is not discourse alone and the analysis should not be limited to the text, but must move beyond the text to look at how organisations operate and how this is reflected and reinforced in accounts of everyday experience. This approach implies looking at issues of power and organisation. This incorporates an understanding focused at an organisational level and not confined to discourse. For example, in looking at issues of organisational and professional cultures within the health service.

However, such an analysis would incorporate a knowledge of organisational processes and dynamics within the health service. This has not been attempted here. What has been shown here is that there is real confusion in health professionals' accounts of depression. There is a powerful organisational definition of the problem of depression, which determines how that problem is defined, who treats depression and how the problem is understood, in terms of power holders within organisations. There is little account of depression in terms of the subjective experience of the individual who is depressed.