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

VOLUME 2

by

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INTRODUCTION

In this chapter, literature on women and depression and on motherhood is reviewed, prior to the presentation of Study IV in the next chapter, where women who were mothers were interviewed about their experiences of motherhood and depression. This chapter discusses approaches which were of importance in the development of this research project and their implications for the development of the project, looking at how the issue of gender has been considered, how women's experiences of depression have been theorised, and how gender has been theorised as incorporated into the experience of self. It is argued that the importance of gender as subjectivity can be understood in terms of a Meadian model of social interaction (Mead, 1934) (see Chapter One, Part II, sections 3, 4 and 7; and Chapter Three, Part II): that the experience of gender is both subjective and social, and that it is through the experience of self in social interaction that experiences of gender are incorporated into experiences of depression.

The higher prevalence rates of depression in women than men have been considered in the research literature in terms of sex and gender. Sex refers to biological differences in maleness and femaleness, for example reproductive physiology; gender refers to socio-cultural differences, experiences of roles, behaviours and personal characteristics of men and women (Lips, 1978).

1. Epidemiology of depression

Recent research on the epidemiology of depression in the West (W. Europe and N. America) suggests that women are twice as likely to become depressed as men (McGrath, 1990; Nolen-Hoeksema, 1987; Weissman and Klerman, 1977).

Attempts to explain the difference in terms of a report bias, that women are more likely to report depressive symptoms than men or that depression in men is likely to be masked by other symptoms or disorders, have generally proved unsuccessful. It appears that the sex difference in prevalence rates reflects a true difference (Nolen-Hoeksema, 1987, 1990).

However, the controversy generated by the issue has led to suggestions that depressive syndromes should be redefined to take account of the symptoms which men do display

(Hammen and Padesky, 1977). This leaves open the question of what is depression, and has implications for mainstream clinical and medical models of depression.

2. Causation

Attempts to explain the sex differences in prevalence rates have focused on models of causation and, as argued in Chapter One, there has been less interest in the question of the phenomenology of depression, in terms of what individuals actually do experience in depression.

Two broad approaches to causation can be identified, in terms of locating the problem in the *individual* or in the *environment.* The evidence suggests that sex differences in prevalence rates of depression cannot be biologically explained (McGrath, 1990; Nolen-Hoeksema, 1990) and that biopsychosocial (McGrath, 1990) or psychosocial (Nolen-Hoeksema, 1990) explanations are more convincing.

In social science models of causation a distinction is made between vulnerability factors and precipitating causes of depression, so that whereas vulnerability in psychosocial models may be located in the individual, precipitating factors may be located in the social environment (see Chapter One). Broadly then, the occurrence of depression in women is explained as a reaction to social and environmental factors mediated through individual vulnerability.

Part I of this review will consider the issue of gender in models of depression. Gender has rarely been considered as an issue. Even the antipsychiatry movement, with its emphasis on the deconstruction of madness and on understanding apparent "madness" in its own terms, failed to look at the question of gender: madness was deconstructed from a male viewpoint which failed to look at the meaning of female experience (Ussher, 1991). Women's madness is a convincing label used to explain women's behaviour in terms of individual pathology rather than looking at their experiences from a female viewpoint as the result of social and cultural constraints (Ussher, 1991).

Part II of the review will then consider motherhood, as an experience of gender and identity, and relations between experiences of motherhood and experiences of depression.

PART I THE QUESTION OF GENDER

1. Depression and female reproductive biology.

Biological models which seek to explain depression through female hormonal causation will first be considered, as powerful models which construct being female as part of the pathology and morbidity of depression. Hormonal explanations link depression to women's reproductive cycles. These explanations will be discussed briefly here, in reference to pre-menstrual symptoms of depression, post-partum depression and menopausal occurrence of depression, with the aim of illustrating that the availability of hormonal explanations constructs being a woman as part of the pathology of depression through female hormones.

Depression has been linked to pre-menstrual syndrome and has led to the controversial introduction of "late luteal phase dysphoric disorder" by the American Psychiatric Association in their 1987 Diagnostic and Statistical Manual (APA, 1987; Nolen-Hoeksema, 1990). However, the evidence is not convincing. While there is evidence that some women experience depression in the pre-menstrual phase (Rivera-Tovar and Frank, 1988, cited in Nolen-Hoeksema, 1990) this may have a psycho-social explanation and be linked to the social construction of menstruation as problematic. For example, Olasov and Jackson (1987) and Abplanapet et al. (1979) suggest that, though women do report an increase in negative mood during the pre-menstrual phase, this may be because of their expectations of negative experiences and they may report what they think they should be experiencing. Women have been taught to experience negative mood in the pre-menstrual phase and this may influence what they do experience (see for example, Parlee, 1973; Clarke and Ruble, 1978). Furthermore, there is no evidence that depression experienced in the pre-menstrual period is any different from depression experienced at other times, and few women only experience depression in this period (Rubinow and Roy-burne, 1984). Depression experienced in the pre-menstrual period may be simply an exacerbation of underlying forms of depression, with more complex explanations than the simple explanation of female hormones, explanations which are located in women's lives and social experiences.

Postpartum depression has long been considered a distinct form of depression, and identified in the clinical literature as psychotic and non-psychotic postpartum depression, and "the blues" (Cutrona, 1982). However, some form of feeling low, blue or depressed is a normal reaction to the birth of a baby and the severe adjustments a woman has to make in her life. Such feelings can hardly be considered as an illness, and may be better explained in terms of social and psychological factors surrounding childbirth, expectations of motherhood and support available in early motherhood

(Nicolson, 1988). Biological explanations have focused on the hormonal changes (Cutrona, 1982), but the evidence is not convincing and explanations in terms of psycho-social stress are better supported (Nolen-Hoeksema, 1990).

Menopause has also been associated with increased rates of depression and until 1980 was labelled as a distinct depressive syndrome, "involutional melancholia" (Nolen-Hoeksema, 1990). But there is also evidence that psycho-social variables are more clearly associated with depression at menopause than are hormonal changes: for example, Nadelson et al. (1983) found that women who experienced the most distress at menopause were women who had relied on child-bearing and child-rearing roles for their status and self-esteem. Indeed, the American Psychiatric Association dropped the label of involutional melancholia from the third edition of the DSM (APA, 1980) because there was little evidence of increased rates of depression after menopause (Nolen-Hoeksema, 1990). For example, Weissman (1979) found no significant differences in symptom patterns and overall levels of depression among women across the reproductive lifespan.

The evidence for biological explanations of sex differences in the prevalence of depression is not convincing (McGrath, 1990; Nolen-Hoesksema, 1990). On the contrary, through the pathologisation of women's reproduction, female biology and being female itself becomes a part of the pathology of depression, since all women are at risk by virtue of menstruation, childbirth and the menopause (Ussher, 1989). McGrath (1990), looking at risk factors in an extensive review of the literature on women and depression, argues that it is the interaction between women's biology and their environment which needs to be examined and that what is required is an understanding of the social construction of female biology, in a biopsychosocial approach which looks at women's experiences in context and across the lifespan. What is at issue is how women understand their experiences through the reproductive cycle. For example, the experience of pre-menstrual syndrome is related to the social construction of menstruation as a negative experience and to the medicalisation of pre-menstrual experience as pathological through the concept of pre-menstrual syndrome (Ussher, 1989).

2. Sociological approaches to women and depression.

Consideration of the higher prevalence of depression among women than among men in terms of gender, implies an approach which looks at women's social and environmental experiences. But how far has the issue of gender been considered? Sociological approaches often fail to address the problems experienced by women and fail to look at

the reality of experience for women. Doing so depends on taking on board women's own accounts.

For example, Brown and Harris (1978) in their structured interview study of women in a London community (see also Chapter One) provide no rationale for their work on women as an issue of gender: they research women because they exhibit higher rates of depression than men and because women are more easily accessible when using community surveys. The choice of women as the object of the survey was determined only by considerations of cost and availability. There is no interest in the issue of gender.

> "Another feature of the research, which perhaps needs some explanation, is its concentration on women. This stemmed not only from the decision to look at untreated depression but also from the decision to take as a comparison group a random sample of people without depression from the same community from which the patient group was drawn. In order to avoid bias, the sample not only had to be random but we also needed as many people as possible to agree to cooperate in what we knew would be a lengthy interview... Such an interviewing programme is expensive and one way to reduce cost was to study women only, as they probably suffer from depression more often than men... It also seemed likely that women, who are more often at home during the day, would be more willing to agree to see us for several hours, the time we needed to collect our material." (Brown and Harris, 1978, pp. 21-22).

2.1. Social roles

The concept of social roles has been used to explain why women are more vulnerable to depression than men. But the issue is seen as an issue of social structure rather than addressing the individual's experience of a particular role and the meaning of that role to her. There is evidence, however, that traditional female roles are associated with high prevalence rates of depression in women. This will be considered here in reference to women's roles as mothers and housewives, and the "protective" role of paid employment. The importance of the concept of role will then be considered.

2.1.1 Motherhood and depression

Women's risk of depressive symptoms has been found to be higher among mothers with young children (Brown, Ni Brolchain and Harris, 1975; Perlin and Johnson, 1977; Radloff, 1975), and this may be due to the low social valuation of childcare and mothering. Brown and Harris (1978) suggested that women with young children who

have no work outside the home are particularly vulnerable to depression and that, following the work of Oakley (1974) on women's experiences of childcare and housework, this may be due to the low social status accorded to childcare and housework. Following the work of Gavron (1966) who suggested that women with young children felt both trapped and undervalued in their work in the home, Brown and Harris (1978) argued that the low social value and recognition of women's roles as wives and mothers may be a causal factor in depression, linked with the occurrence of low self-esteem.

2.1.2 Depression and the housewife role

Depression has been associated with women's roles as housewives, as in 'the noxious nature of the housewife role' theory of depression (Repetti and Crosby, 1984). It is not clear what the basis of the association is, though Repetti and Crosby (1984) found that high levels of dissatisfaction were related to higher levels of depression for housewives than any other occupational or family status group. But this also seems to depend on the quality of the woman's experience, since the extent to which being a housewife is related to depression depends on the social status of the couple and the quality of their marriage. One possible explanation may be that wealthier wives could hire others to perform household tasks and themselves participate in more activities outside the home (Repetti and Crosby, 1984).

There is also evidence that levels of depression in housewives may be linked to the quality of their relationship with their husband. Vanfossen (1981) found that among housewives there was a significant relationship between levels of depression and the affirmation received from their spouse and the level of intimacy in the marriage, and that women whose husbands shared the housework were less likely to be depressed. Brown and Harris (1978) identify the lack of a supportive partner and the absence of paid work outside the home as vulnerability factors for depression in women.

2.1.3 Paid employment: a protective factor?

The above evidence may suggest that depression can be protected against by employment outside the home, or multiple roles. Theories explaining vulnerability in terms of social roles also suggest that individual identity may be constructed through the performance of several roles, and that this may be protective against depression. Thus Thoits (1986) has argued that individuals who have several roles are protected from depression. However Gove and Tudor (1973) argue that while a single role as a housewife may lead to few sources of gratification and be associated with depression, women who work and have a husband and children or both may be also vulnerable to stress because of role overload and that this may be associated with depression. Women

who both work and have a family are expected to carry out two full-time jobs, and these may have opposing demands: to be patient, self sacrificing and supportive at home and self-sufficient, aggressive and achievement oriented at work (Nolen-Hoeksema, 1990).

Women who have no children may also be vulnerable to depression, through their roles at work. Their identity as women may be challenged and there is evidence that infertility can be associated with feelings of failure and depression (Woollett 1987, 1991).

In addition, women are likely to be undervalued at work: historically this has occurred through legalised sex discrimination (Ehrenreich and English, 1978), whereas now it occurs through institutionalised practices which, though more subtle, may still carry the same message and hence be more difficult to identify and act against. Women are likely to work in lower status and poorly paid jobs, associated with traditional female qualities of servicing and caring for others, and where they do work in professional posts are unlikely to achieve promotion as rapidly or be paid as well as their male peers (Faludi, 1992).

The evidence from multiple role theory also suggests that women's experiences may be variable between roles and that this may be a source of both protection and vulnerability to depression. What may be at issue is the quality of roles and status rather than the occupancy of particular roles and status (McGrath, 1990), which points again to the need to look at meaning through analysing women's own accounts of their experiences.

2.1.4 Social roles and individual experience

The concept of role is meaningful as a social construct, in terms of the opportunities it affords for social relationships and in terms of the social values put on a particular role. In the research literature, the issue of identity is related to social roles but there is little attempt to theorise the relationship between gender, roles and self. Through the concept of role, the problem is located in social structure but this neglects to look at the individual's experiences or their meaning for the individual. Roles, identity and self are not theorised in a way which highlights the processes whereby sense of self is formed in relation to experiences of role and identity.

Brown and Harris (1978) do not investigate how the social construction of roles and identities is incorporated into experience of self. There is no attempt within their own study to consider how individuals form a sense of identity or a sense of self, although it is recognised as an issue.

Brown and Harris (1978) suggest that a woman's view of herself as a successful wife and mother may be crucial in determining her experiences of depression, and that the critical relationship may be that between socially constructed roles, identity and experiences of self:

> "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)

It is not simply a question of the social value put on a role and the opportunities for social contact focused around a role, or of the social demands associated with a particular role or combination of roles, but a question of the interaction between the individual and their social world. The problem then is how to link issues of the social value of roles, the social relationship provided within roles, and the individual's sense of and experience of self. This may be approached through looking at how the individual herself interprets her roles, and the meaning and implications for her sense of self of her expectations and experiences within particular roles and of the construction of her social identity around roles.

As has been discussed earlier (see Chapters One and Three), Oatley and Bolton (1985) developed a social cognitive approach to depression which conceptualised the self as constructed through role relationships, and the onset of depression as occurring when critical role relationships were lost, amounting to a loss of self. However, this approach did not look at the meaning of individuals' experiences of roles (as was discussed in Chapters One and Three). Instead roles have been approached as social issues, which affect the individual, rather than looking at how roles are incorporated into subjective experiences of self and identity.

3. Subjectivity

3.1 Meaning, and subjective experiences

Although Brown and Harris (1978) claim to address the individual and the complexity of individual experience they do not fulfil this aim. Though aware of the importance of questions of meaning they do not in fact address them. They suggest that they are concerned not just with what changes a woman experiences *"but with how she perceives and reacts emotionally to these changes"*, (Brown and Harris, 1978, p.5).

Brown and Harris (1978) deliberately exclude from their study considerations of the subjective meanings of events for individuals and of individuals' reflections upon events. They argued that to use such data would be to introduce "bias" into their research, and this argument is consistent with their claim to look at the "objective" meaning of events, within a positivist framework. They claimed that threat can be measured objectively, as a measure of the importance of events given the social context of those events. In the discussion of their results, Brown and Harris (1978) appear not to see the contradiction between their emphasis on the meaning of particular events and their exclusion of any consideration of personal or subjective meaning. They are concerned to develop impersonal scales of meaning which are contextually dependent:

> "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 measured 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. Their italics.)

Although Brown and Harris do suggest that:

> "We need to think in far more detail about the way women think about and experience their depression" (Brown and Harris, 1978, p.274),

they do not see this as in any way weakening their conclusions or model. They argue that:

> "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". (Brown and Harris, 1978, p.274)

Questions of meaning are neglected within their causal model of depression, which looks at internal individual characteristics and external social causation. The specific experiences of the individual are reduced to "objective" measurements and it is felt that this is a sufficient analysis. They argue that:

> "For methodological reasons we have placed most weight on 'contextual' ratings which were designed to record what most women would have felt given the particular circumstances - past and present - of the individual woman. But while we did this for methodological reasons we also believe such judgements on the part of the investigator are essential for social science research." (Brown and Harris 1978 p.274)

Brown and Harris (1978) do not look at the interactive process of the individual's experiences in the social environment since they see no problem in the distinction of research as *either* individually oriented *or* socially oriented, since the problem is merely in keeping the balance between these approaches. This can be linked to their assumptions of dualism, where the individual and society are seen as separate and not as interactive.

> "Both individual-orientated and society-orientated studies are required; both are part of sociology and both are essential. The need is for each to remember the other. It is too easy for the broader approach to ignore the complexities of the individual's immediate social milieu and for the more detailed approach to get lost in the intricacies of the individual personality." (Brown and Harris, 1978, p.293)

There is no conscious consideration of the socio-cultural context through which events become meaningful. However, it seems to me that the socio-cultural context is inevitably incorporated into the independent assessors' "objective" judgements of the importance of an event for the average woman, although Brown and Harris (1978) do not take account of this. Their claims to "objectivity" are not sustainable, while they have consciously ignored any consideration of subjective meaning. Their claimed aim is to look at individuals' experiences and the perceptions of individual women, but instead meaning is considered only in terms of social context and is linked to other specifically identified events and circumstances.

3.2 Subjective experience and socio-cultural contexts

Work in the area of the psychology of women has emphasised the need to take account of subjective experience and specifically of the experiences of women, and this includes an awareness of the socio-cultural environment. Jack (1991) used a qualitative methodology in her study based on women's interview accounts of their subjective experiences of depression (see Chapter Three, Part II, section 5.2). Jack (1991) emphasises the need to take account of subjective experience in order to address the

problem, posed by Brown and Harris (1978), of explaining the interaction between inner (individual) and outer (social) worlds, in order to explain the experience of depression as a social phenomenon, and specifically in order to understand the importance of role identities:

> "In order to understand how a woman's external and internal worlds affect and depress her, we must learn about how she sees and interprets them. What affects her is not some clearly perceptible, objective actuality, but experience as she perceives it. To learn of it there is no better source - indeed no other source - than the woman herself." (Jack, 1991, p.23).

Jack's (1991) work on women's experiences of depression develops a socio-political analysis, which is concerned with the construction of meaning, whereas Brown and Harris (1978) were concerned with particular events and circumstances but not the meaning of those events to the women who experienced them. She does recognise a background of collective or shared ideas about femininity among the women she interviewed, although she does not claim to be able to generalise from the observations of the women she interviewed. She takes account of the women's 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)

Following Gilligan's (1982) work on women's experience of self as relational, Jack (1991) investigates women's experiences in intimate relationships. The nature of relationships is examined in the context of women's socio-cultural environment in order to understand women's experiences of depression. So for example, concepts of dependency and self-esteem, as linked to depression, become problematic when women's experiences of depression are understood in terms of their relationships. Women's experiences of depression can be understood as loss of self not loss of other:

> "Depicted as enmeshed in dependence and hanging on to relationships like "leeches", depressed women describe themselves as isolated. They fear not loss of other but loss of self. The clinical literature says that women have a problem with separation and self-esteem because they are dependent on their relationships; the women cast their problem as one of

> establishing and maintaining connection. Women describe their depression as precipitated not by the loss of a relationship, but by the recognition that they have lost themselves in trying to establish an intimacy that was never attained. For most depressed women the sense of hopelessness and helplessness stems from despair about the possibility of bringing their own needs and initiative into their relationships, and from their equation of failure of attachment with moral failure." (Jack, 1991, p.27).

Similarly, Cadbury (1991) has argued that the identification of dependency in women as a cause of depression ignores the experiences of women and the importance of the cultural environment in shaping their experiences, imposing an alternative value system (patriarchy) and evaluating women's experiences with a hidden bias. Birtchnell's (1988) work, on the links between women's experiences of depression and dependency, fails to take into account the reality of women's social roles structured in terms of caring for others, their economic and social positions, and the importance of gender in restricting women to these roles.

4. Power

It is unclear, however, how social roles or gender roles might lead to depression. Radloff (1975) has argued that this may be explained through learned helplessness theory (Seligman, 1975): women lack control over their lives and this can lead to feelings of helplessness and hence depression. Thus women's experiences of powerlessness may be directly linked to depression. However, it is not clear why helplessness should lead to depression, and the link between women's lack of control over their lives and depression remains unclear. It is not clear what it is about women's experiences which is depressing, since while they may often feel powerless and lack control over their lives, how does this explain experiences of depression? In addition, many women who are depressed may also be actively struggling to achieve goals, even of survival, rather than behaving passively as indicated in learned helplessness theory.

5. Summary

The issue of gender, as a social construction, has largely been ignored in social science approaches to depression in women. The focus has been on explaining depression in terms of causes located in the social environment. As argued in Chapter One, there has been little attempt to explain how external social causes are incorporated into an individual's experiences.

Furthermore, attention to the concept of roles has produced contradictory results, which suggest that an explanation structured in terms of objectively defined social roles is insufficient, and that the concept of role is inadequate in investigating individuals' experiences. The concept of role could be deconstructed to look at experiences in terms of relationships, social identity, functions and value to others. Work on multiple roles has suggested that it is the quality of roles which may be critical. It may be that women are expected to meet conflicting demands in the domestic and public spheres, and that qualities such as nurturance, emotional supportiveness and passivity, which they are expected to demonstrate in domestic roles, are the opposite of qualities such as active assertion, authority and intellectual rationality, which are usually valued in the public sphere (Nolen-Hoeksema, 1990).

But what is critical here is the experience of self and identity in roles, how women make sense of their relationships, their expectations of themselves and of others in roles, and how these are incorporated into sense of self. The social construction of gender identity, and the construction of women as acceptable, may depend on their successful fulfilment of traditional roles, with success being defined according to social ideology surrounding femininity. These questions will be addressed next, looking at the social construction of motherhood and femininity and women's experiences of motherhood.

PART II THE MEANING OF MOTHERHOOD: SOCIAL CONSTRUCTION, GENDER IDENTITY AND SUBJECTIVITY

The psychological and sociological evidence on depression in women has suggested that women's roles as mothers may be linked to depression, whether as single roles or in combination with other roles. However, this approach to motherhood as a role ignores the meanings of subjective experiences of motherhood. An alternative approach is proposed here where motherhood is seen in terms of women's subjective experiences, as the incorporation of social experience, as subjectivity, and as an experience of self.

1. The choice of motherhood? The construction of social and personal identity.

Motherhood is not a unitary nor a simple experience (Nicolson, 1993b). It is contradictory, exists at several levels and involves diverse experiences. Yet women are identified in simple terms as mothers, by men and by themselves, implying that motherhood is a common and unitary experience.

Women experience a complex identity as mothers (Richardson, 1992) and this may be potentially contradictory. Women are defined from childhood as potential mothers and expect to become mothers, but the actual experience of motherhood may contradict their expectations (Richardson, 1992).

1.1 Social and personal identity

Being a mother determines a woman's personal and social identity (Nicolson, 1988, 1993b), but it also determines a woman's identity whether or not she has children. Motherhood can be seen as intrinsic to womanhood (Nicolson, 1993b).

Studies of adolescent girls suggest that motherhood and marriage may be part of gender socialisation. Hazel Beckett (1986) and Chris Griffin (1986, 1989) both found that motherhood and marriage are seen as eventual and inevitable aims among school leavers. Beckett (1986) found that young women saw a combination of marriage, motherhood and a career as non-problematic, and that the greater choice of occupation available to women has led to greater flexibility. However, motherhood was still seen as central and neither was it seen as preventing a career nor was a career seen as an alternative and equally acceptable choice to motherhood. Griffin (1986) suggested that few choices were available to young, working class women in terms of employment, and that motherhood was both the most easily available choice and potentially the most well rewarded choice.

Sharpe (1976) identified ways in which cultural stereotyping was used to identify ideal and typical characteristics of women, among Afro-Caribbean, Asian and White girls living in London. She suggested that the cultural stereotype of motherhood with which girls were presented, and on which they based their own expectations, was an idealised image but one which they accepted despite the evidence presented in their own mothers' experiences. The idealised version includes fulfilment, satisfaction, relative freedom and adult status.

Part of the explanation for the power of the ideal may be the poor alternative options available to some women within paid employment or unemployment. But it may also be that motherhood is a powerful ideal, not just because it is the best available option but because it represents the only potential opportunity to achieve relative autonomy. This potential may override the low social status of motherhood, since motherhood is portrayed as both a private and domestic experience and implicitly as a way of escaping the public sphere, and thus it may be seen by some women as a positive opportunity to achieve some autonomy.

Motherhood is therefore not so much a choice but an assumption around which other choices are made. It is an experience into which women are socialised as part of their identity as women, and hence something which they may not consciously consider as an option which they may or may not take. While women may apparently choose to have children, very often they may simply not fail to chose *not* to have children and on an unconscious level may accept childbearing not in terms of a positive choice but as something inevitable. Moreover, although motherhood affects identity it is also built into every woman's identity whether or not she has children, and is problematic in terms of a choice not to have children as well as the actual experience when a woman does have children.

Socialisation into the female role equates marriage and motherhood with femininity, and women may see themselves as defective women if they fail to do both. Motherhood may be seen as the achievement of adult feminine status (Woollett, 1992). Women who do not have children may be seen as inadequate women.

1.2 Social pressure and personal choices

Women may be unconscious of the social pressures operating on them, and of the structural and social constraints involved in their potential roles as mothers, and they may interpret these as personal issues. The pressure to have children is both powerful and hidden since it is constructed within the terms of female identity. Thus women may not be aware of this pressure but see motherhood as a natural stage in their

development, not in terms of a choice but as something inevitable, with their choice being limited to the question of when to have children. It may be *not* having children which has to be explained: women opt out of rather than into motherhood (Woollett, 1987).

A woman's identity as a mother can be seen to be socially constructed, but in personal terms, so that motherhood is understood as a personal choice and as an experience confined to the personal and private spheres. For example, women may personalise structural difficulties, such as the timing of reproduction, and interpret the structural problems involved in motherhood, such as the availability of childcare and career breaks, in terms of personal choices of the 'right' time for them (Currie, 1988).

While women may be unaware of the social constraints operating on them, and see motherhood in terms of femininity and as a personal issue, their choice of motherhood as an identity will be constrained and their experience of motherhood will be rendered personal and individualised.

1.3 Acceptable motherhood

Womanhood may be associated with motherhood but the circumstances in which a woman has children may render the association problematic. The social context of acceptable motherhood and thus womanhood is clearly proscribed, and heterosexuality, marriage and motherhood go together. This combination is needed in order to be an acceptable woman, (Gittins, 1985; Nicolson, 1993b). Thus a woman's identity is determined in terms of heterosexuality and marriage and these are incorporated into the social construction of acceptable motherhood.

Motherhood is socially problematic for groups who fall outside this sphere, for example for lesbians (Burns, 1992) and for unmarried women (Boyle, 1992; Macintyre, 1976). There is also evidence that women's experiences of single motherhood may be less problematic than motherhood is for married women, in that they experience more power and control over their own lives (Sharpe, 1984).

Marriage is commonly associated with motherhood (Woollett, 1992) and women who are married and who do not have children may also be viewed as problematic (Campbell, 1985).

Conversely, women who fit the stereotypical norm, in that they are married and mothers, may not feel entitled to experience problems and may be reluctant to see their own experiences as problematic, as argued by Friedan (1963) in her study of white

women in American middle class suburbia. Women who have achieved the perceived norm for women, at least in western, white, middle class society, may not themselves validate their experiences of problems nor their right to have any problems at all.

1.4 The value of motherhood.

Motherhood is seen both as low status and as defining in women in contrast to the qualities required for high status occupations. Women may lose valued aspects of their identities, for example in the loss of an identity as a skilled worker on giving up work (see Smith, 1990). The experience of motherhood also deprives them of the opportunity to use skills which are socially valued.

Skills valued in paid employment may not be incorporated into the daily lives of women who are mothers and who no longer have paid employment. This loss of opportunity to use recognised skills may then feed back into women's assessment of themselves in the mothering role. For example, women who are full-time mothers may come to feel that they are unable to do tasks demanding intellectual skills (Gavron, 1966; Nicolson, 1988). Women may also see motherhood as skilful but be positioned between contradictory assessments of valued skills, since the skills of nurturing and caring required in motherhood stand in contrast to the assertive and competitive qualities required for success in many areas of professional employment (Nolen-Hoeksema, 1990).

Ruddick (1982) has argued that women acquire skills in motherhood which are mistakenly seen as negative, such as humility and cheerfulness which may be misinterpreted as self-effacement and denial. But these skills may be strengths evolved to cope with the difficulties of motherhood and may be assessed in negative terms because they are associated with women's subordinate position. The negation of women's experiences in motherhood may be seen as a direct reflection of women's subordination.

Far from recognising their own skills in motherhood, in coping with stresses and fulfilling a difficult task, women may blame themselves for, and see their problems in terms of, their own inadequacies (Boulton, 1983; Brown et al., 1986; Nicolson, 1993b). This may be based upon the social construction of motherhood as non-problematic and the isolation of women in what is primarily a domestic and private experience.

Women may thus experience themselves as inadequate in motherhood, which defines femininity and their status as women and which is central to validation of their identity as women. At the same time, motherhood is a low status occupation which defines

women as "just" women and "just" mothers. Thus women may face a contradiction between the need to confirm their identity as women through motherhood and the impossibility of achieving a valued identity as mothers.

1.5 The development of women as mothers: psychological evolution?

Nancy Chodorow (1978) argued that the practice of motherhood is reproduced within the social context of patriarchy, and that it is the inevitable product of historical conditions, the division of labour and the structure of childcare, as children psychologically evolve to meet existing, dominant social structures and practices. She argues that the mother-daughter relationship itself is guaranteed to produce women with the capacity and desire to mother.

Chodorow (1978) constructs an argument for psychological evolution in response to social structure. Her argument focuses on personality rather than social experiences. She suggests that such development is inevitable, but she overlooks the possibility of individual choice and she argues for some sort of psychological innateness.

Her argument is based on a model of the individual evolving in response to the environment but not reflecting upon it nor acting within it. It is also based on a unified model of society and ignores the diversity of social conditions and of economic constraints, and the institutional and structural diversity which affects individuals' experiences. She neglects the conflicts experienced by many women as mothers. For example, many women experience the lack of support in childcare as problematic and experience conflict between the demands of their children and their own wishes for autonomy and achievement in other spheres (see Study IV, Chapter Eight). Women are not simply passively defined as mothers but have diverse experiences of motherhood and interpret these experiences and act in different ways.

2. The social construction of motherhood

2.1 Non-problematic versions of motherhood

Motherhood has been popularly constructed as non-problematic and as a positive experience for women. It has been constructed in terms of romanticism and idealism (Ussher, 1990), drawing upon Madonna-like images of women whose needs and femininity are fulfilled through their relationship with their child. Through such images, it can be suggested that women have no needs which are not fulfilled within the home: motherhood is both what every woman wants and what all real women need.

Motherhood has also, and to some extent by contrast, been constructed as a powerful and influential role (Kitzinger, 1978), with women seen to rule within the family and the home.

Motherhood includes duties and responsibilities rather than power and influence, and women are accountable to others for the ways in which they fulfil their responsibilities and duties. These duties and responsibilities are not accompanied by significant sources of power and influence. So for example, within the home women are seen as fulfilling the needs of others, of their children and their partners, and are answerable to men for the successful running of the home (Nicolson, 1993b). The reality of this may be that they are economically dependent on men and have no real choices. In the recent past, and to some extent still, legal power over women and children has been held by men (Lummis, 1982).

Although mothers may be seen as powerful over their children, the terms in which this "power" is constructed make it a responsibility rather than power, one for which they are accountable to others. Thus there are right ways to mother children (Marshall, 1991), and women are blamed when they fail to fulfil these ideals. Mother blaming is a popular social practice, which exists at the level of the individual, and in popular culture in the idea of the heartless mother (Dowling, 1981; Sayers, 1988).

An idealised version of motherhood is one against which women can only fail, and only blame themselves for their own failure. There is little account of the difficulties and problems experienced in motherhood, nor recognition that it is a difficult and mostly thankless task. Motherhood is constructed as an ideal within the terms of popular culture and within science. Science can be seen as shaping and defining accepted popular "knowledge" according to the knowledge claims and needs of the powerful (Foucault, 1973), and as constructing as normal what is in fact acceptable to those who hold power or to society as it is currently constructed. Thus "knowledge" is constructed in a way which does not challenge and which may reinforce the social structure, and which in turn affects how individuals interpret their own experience. Idealised versions of motherhood, and women's beliefs that there is an ideal which they ought to aspire to, can be explained as constructed to reflect the needs of men (Nicolson, 1993b). Men, through rendering motherhood as natural and non-problematic, are able to define it as women's work, keep women within the domestic sphere, and at the same time render women accountable for any problems they may experience as mothers.

Thus despite evidence that motherhood is problematic (see for example, Gavron, 1966; Boulton, 1983) this has not been taken up within popular versions of science nor

incorporated into popular culture. The idealised version of motherhood remains strong. The reality of the experience is a shock to many women (Nicolson, 1988) and the stresses, difficulties and disappointments experienced in the early stages may explain so-called experiences of post-natal depression (Nicolson, 1988; Mauthner, 1993). It may be that mothers cannot easily tell other women that motherhood is not the idealised, one-dimensional experience which is so strongly portrayed in society, since to do so would confirm them as "bad" women.

2.2 Scientific versions of motherhood.

The ideology of motherhood, as a construction of femininity, is powerful in shaping women's experiences. The social construction of motherhood as an ideal of femininity may also be reflected and reinforced in scientific research. Boulton (1983) identifies ambiguity in Gavron's (1966) work and claims that Gavron represents a view of motherhood as superficially positive at the same time as she sees women in conflict. Boulton (1983) herself identifies two contrasting themes, of women experiencing the daily routine of motherhood as frustrating, and their reflection on motherhood as meaningful and as giving them a sense of purpose.

Motherhood has been constructed in biological terms as a natural and inevitable "maternal instinct", and this can be seen underlying popular versions of motherhood and of woman, as both desiring to have children and to care for them and naturally and easily fulfilling her destiny by finding the required responses within herself (Badinter, 1981). In this version, motherhood is constructed as a biological imperative (Wilson, 1978). Motherhood is not a question of socialisation but of natural development (Nicolson, 1993b) and it is women who do not want or cannot have children who are problematic (Woollett, 1992).

This version of motherhood as instinctive and natural has been developed in psychoanalytic accounts, where good mothering is a natural response, where women become fulfilled through motherhood and where they exist in a symbiotic relationship with their child, both mother and child having interdependent, reciprocal and instinctive aims (Balint, 1949, 1965; Boulton, 1983). Psychoanalytic versions construct motherhood in terms of instinctual drives and as the culmination of women's psychosexual development (Boulton, 1983). Motherhood is constructed at the level of the individual personality (for example, Breen, 1975; Chodorow, 1978) and remains at that level: the focus of interest is on individual difficulty. There is no consideration of common or group experiences (Boulton, 1983), and no consideration of social influences or social factors. The psychoanalytic approach is essentialist and implicitly biological, seeing motherhood as based on a woman's biological relationship with her child and

conceptualising it in terms of instinctual drives. There is no need within the terms of the psychoanalytic account to consider motherhood as a socially constructed experience, but at the same time and for this reason there is no room within psychoanalytic accounts for a consideration of the complexity of women's actual, subjective experiences. Instead, the focus is on clinical experience (Boulton, 1983) and on clinical versions of women's problematic experiences in pregnancy and problematic experiences with infants, versions which are constructed within a medical/ clinical framework of pathology. There is no consideration therefore of what women do experience everyday as motherhood, no attempt to look at motherhood from women's viewpoint or at motherhood as experienced throughout and within the context of women's lives.

Scientific notions have been based on assumptions of motherhood as instinctual and natural. For example, assumptions about "bonding" and "maternal deprivation" are in common use and are powerful in psychological literature surrounding motherhood, although there is very little evidence to support them (Phoenix and Woollett, 1991). There is little psychological or historical evidence that women have ever felt an innate desire to bear children (Dally, 1982; Whitbeck, 1984; Badinter, 1981).

Developmental psychology focuses on child-centredness and child sensitivity as essential to mothering, and the mother's behaviour is assessed solely in relation to the needs of her child (Phoenix and Woollett, 1991). Bowlby (1969) and Ainsworth et al. (1974, 1978) constructed models of normal development as dependent on the mother's sensitivity to her child, and suggested that a child's later problems could be caused by inadequate mothering, thus setting up the mother as the source of blame and as failing in her natural role if she did not respond to her child in the "right" way, so ensuring its non-problematic development. Psychological approaches which emphasise the role of the wider social context in development (for example, Bronfenbrenner, 1979) have been ignored within a literature which sees child development in terms of mothering rather than parenting, and as contained within the mother-child dyad (Woollett and Phoenix, 1991).

2.3 The incorporation of scientific knowledge into popular versions of motherhood

Scientific assumptions about motherhood have been incorporated into popular notions of motherhood. They are also specifically taught to women in ante-natal classes and through the psychological and childcare literature which women are expected to read in preparation for motherhood.

At one level, scientific knowledge influences popular ideologies of motherhood and itself incorporates and reinforces the ideological assumptions whereby motherhood is seen as natural to women. However, at another level, motherhood has become the province of experts, with women seen as needing information and training in how to mother in the "right" way. There is a contradiction between the assumption that motherhood is women's innate destiny and the increasing medicalisation of pregnancy, childbirth and childcare. This emphasises that motherhood is skilled and serious and that women need to have formal knowledge of it (New and David, 1985) and at the same time suggests that, while motherhood defines women, women are not themselves capable of regulating it but need regulation by medical experts. The medicalisation of motherhood has been extended from pregnancy and childbirth to childcare (Woollett, 1991), but ignores the reality of women's experiences and constructs norms against which women's experiences of motherhood as problematic are assessed as pathological, for example in the diagnosis of post-natal depression (Nicolson, 1988).

Scientific approaches, which address the needs of the child and which incorporate assumptions about motherhood as natural and easy, have been incorporated into popular literature on motherhood and childrearing, which women are urged to read so that they can be guided by the "experts" (Woollett and Phoenix, 1991). This literature may imply that mothering is non-problematic, that women naturally love their children and so find childcare enjoyable and fulfilling (Leach, 1988; Marshall, 1991), and that any woman who does not enjoy childcare does not love her children enough (Boulton, 1983). It is suggested that there is no diversity between the interests of the mother and those of the child:

> "So taking the baby's point of view does not mean neglecting yours, the parents', viewpoint. His interests and yours are identical." (Leach, 1988, p.8.).

Marshall (1991), in an analysis of childcare and parenting manuals, has identified powerful themes, around which motherhood is constructed as a wholly positive experience: motherhood is natural fulfilment, mother love is natural, and mothers who experience real depression are unnatural mothers. Marshall (1991) identifies a distinction between the "blues" and serious or "real" depression. The "blues" are experienced by the majority of women, are natural and can be explained through women's hormones. The "blues" may be irrational, but at any rate are not to be taken too seriously. Serious or "real" depression is a medical problem through which the mother is constructed in terms of her failure to adapt to her baby (Marshall, 1991). Thus

women's experiences of depression after childbirth are either not to be taken seriously or are medicalised in terms of the woman's pathology.

Thus, within mainstream psychological accounts, the construction of motherhood as non-problematic is maintained, and the idea that women who experience problems as mothers are themselves unnatural is reinforced (Marshall, 1991). The social context of motherhood is ignored, since it is assumed that women have adequate support. This is in contrast to what women may actually experience: Nicolson's (1988, 1992) analysis of women's own accounts of their experiences in the early months of motherhood suggests that many women do not feel that they receive sufficient or appropriate support and that they feel overwhelmed by the enormity of their task.

Childcare is constructed in manuals within the context of the family and in terms of shared caring between both parents (Marshall, 1991), although at the same time there is a contradictory and unacknowledged emphasis on the mother: as the primary carer and through her responsibility for the father's role she becomes responsible for the child and for the success of the whole family unit. The fact that motherhood is and remains a problematic experience for many women is ignored. Instead, the birth is constructed as the gateway to a non-problematic experience within the family (Oakley, 1980). The family becomes the focus of the woman's being, and is fulfilling and satisfying for her as she obtains her reward from her enjoyment of family life.

There is no attention within childcare manuals nor within popular versions of motherhood to the social and economic circumstances within which motherhood actually takes place. There is little attention to, or validation of, the conflict between the woman's own needs and those of her child, nor to the loss which a woman may feel through the time-consuming and self-consuming commitment demanded in motherhood, (Gavron, 1966; Boulton, 1983; Nicolson 1988, 1992, 1993b; Oakley, 1981b). Nor is there much recognition of the sense of powerlessness and failure women may feel because their children are not models of normal development and because their families, for which they are portrayed as responsible, are not caring, sharing utopias of the human virtues.

The contrast between the childcare manuals and scientific studies of women's actual, subjective experiences in motherhood is marked. The advice given to new mothers, to ensure the normal development of their child, is based on a medical and essentially biological model of mothering which takes no account of the experiences of women themselves. There is a consistent medical/ psychological discourse which presents a non-problematic version of motherhood and which ignores possible alternative versions

(Marshall, 1991). This is a scientific and social construction of motherhood which stands in stark contrast to women's actual experiences, and which constructs motherhood and the mother in terms divorced from the reality of women's lives, as abstract concepts which are nevertheless powerful.

3. Women's experiences of motherhood.

3.1 Feminism and motherhood: validating women's experiences

Feminism stands in an ambiguous relationship to motherhood, since motherhood is central to women's lives and yet motherhood has often been neglected within the feminist literature (Nicolson, 1993b). This may be because of impatience with research which has focused on white middle class women (Nicolson, 1993b), although there are exceptions to this, for example Ann Phoenix's study of teenage mothers (Phoenix, 1991).

Feminist approaches have looked at women's actual experiences of motherhood as part of the experience of being a woman, and have challenged accepted, scientific conceptualisations of pregnancy, childbirth and motherhood (for example, Gavron, 1966; Oakley, 1976, 1980, 1981b; Boulton, 1983; Nicolson, 1988, 1993b). But these challenges have been limited. They have not amounted to a reconstruction of motherhood in terms of women's needs and experiences.

For example, Oakley (1976, 1980) challenged the medicalisation of childbirth and demonstrated how women's control had been eroded through this process. Gavron (1966) and Boulton (1983) looked at the ways in which women experienced motherhood with young children in terms of their everyday lives. Gavron (1966) and Boulton (1983) both looked at how social class affects women's experiences, since money buys a more comfortable home, more domestic convenience and childcare, but also recognised that motherhood is problematic throughout social classes. Both accounts contrast the ideology of motherhood with the frustrations that women experience daily. However, both these and Oakley's (1976, 1980, 1981b) accounts assess motherhood in terms of social factors, and the psychological implications of their work remain implicit rather than explicit.

A potential contradiction can be identified between approaches which seek to validate women's experiences of motherhood as female experiences, which should be controlled by women (for example, Oakley 1976, 1980, 1981b), and approaches which argue for more support for and recognition of the difficulties of motherhood, from men. This contradiction can be resolved through validation of women's experiences in their own

terms, so that the support women are given is the support they see themselves as needing rather than that proposed by scientific "experts".

At the same time, women's experiences of motherhood can only be explained within a wider framework of the social construction of gender identity, as part of women's experiences throughout their lives as a whole. This demands that the importance of women's experiences of motherhood is recognised not simply in social and practical terms, such as childcare arrangements and career breaks, but in terms of the impact of motherhood on women's identity and sense of self throughout their lives. Nicolson (1988) addressed motherhood as a meaningful experience in women's lives and looked at how the meaning of subjective experience was constructed. Motherhood was experienced as depressing, although women themselves were ambiguous about the use of the term "depression".

In feminist approaches, motherhood may be seen both as a problem for women and as a positive experience, which includes caring and nurturing qualities which are not validated within the terms of a male patriarchal and scientific discourse (Ruddick, 1982). These complementary approaches, which may not directly address the complexity of women's experiences, neglect the fact that for many women motherhood is at the same time both important and problematic, and neglect the ambivalence which many women themselves feel as they both validate themselves through motherhood and experience it as problematic. Approaches which address motherhood as a social issue may also run the risk of identifying motherhood itself as a problem or of reducing the problems which women experience in motherhood to social factors, such as lack of support within the home and alternative childcare facilities, which render it problematic.

It may not be "motherhood" which is at issue so much as women's experiences of themselves in motherhood, as part of their lives. The experience of motherhood is related to, part of and not distinct from other experiences, identities and subjectivities, and cannot be considered as a distinct experience. It is implicit in the construction of gender identity that every woman is potentially a mother, and this affects all women whether childless or not.

3.2 Motherhood as an experience of identity and self.

Brown and Harris (1978) argued that vulnerability to depression in women was related to their experience as wives and mothers, and in particular to the difference between their actual or present experiences and their aspirations for themselves in those roles. (The three vulnerability factors referred to below are: presence at home of three or more

children under fourteen, absence of a confiding relationship, and lack of a full- or part-time job.)

> "The relevance for women of the three vulnerability factors occurring in the present would probably lie in generating a sense of failure and dissatisfaction in meeting their own aspirations about themselves and particularly those concerning being a good mother and wife - this giving them chronically low self-esteem." (Brown and Harris 1978, p236).

Boulton (1983) extended Brown and Harris' (1978) work in a small scale, intensive and qualitative study of women's experiences of motherhood. Boulton's original aim was to look at motherhood from a domestic labour perspective, but this proved inadequate since it could not deal with the full complexity of women's experiences as mothers and, she argues, "did violence to the women's own accounts" of their lives, since it ignored or distorted aspects of their experiences.

Boulton (1983) argues that a different conceptual approach is needed, which takes account of social relations in the private or domestic domain. She identifies two different modes of female experience: the women's immediate response to looking after their children and their sense of meaning and purpose in doing so.

Boulton (1983) reconceptualises motherhood in terms of its meaning for women but does not explore the implications of this for women's subjectivity, since her focus is on motherhood rather than the women themselves or the implications of their experiences for them. While she uses subjective accounts to look at experiences of motherhood, she does not look at the significance of these experiences in terms of the wider context of the meaning of the women's lives and the development of their identity as women. For example, there is no consideration of the importance of gender in defining the social and personal identities of women and as incorporated into their social experiences. Motherhood is approached as a limited and contained experience.

This leaves open the question of how motherhood is experienced as an experience of self: how the role and identity of a mother is socially constructed, and how a woman's social identity as a mother and her expectations and knowledge of motherhood are incorporated into her experience of self. These are questions explored in Study IV, Chapter Eight, of this thesis.

3.3 Motherhood and transitions of identity: loss, grief and adaptation.

Women's experiences of motherhood may be interpreted as experiences of changed identity and as a changed sense of self. At the same time, motherhood forms part of experiences of gender and identity, since being an actual or potential mother is implicit in being female. So motherhood involves both a confirmation and a redefinition of identity. While women are confirmed as mothers as "real" women, they also lose their personal identity and social value when they become "only mothers". Motherhood stands in a contradictory and complex relationship to womanhood (Nicolson, 1993b).

The transition to motherhood has been considered as a process of adaptation. The terms in which this adjustment is considered vary from the emotional and physical (Oakley, 1980), to terms of roles and social status (Oakley, 1981b) or a life transition and change in identity (Nicolson, 1988, 1992; Smith, 1990).

Smith (1990) explained motherhood as a transition in self-concept, which he claimed was mostly non-problematic for the women participating in his multi-method study which included the qualitative analysis of interview data. However, Smith (1990) does not take sufficient account of the fact that woman may not have felt free to talk about the problems they were experiencing to him as a man. In contrast, Gavron (1966) found that women tended to see the problems they experienced in terms of personal inadequacies. Women may be placed in a contradictory position, since they may at the same time wish to portray themselves as successful mothers and women and to minimise their problems to others because they see them as personal.

Nicolson (1988, 1992) looked at women's experiences in pregnancy and in the immediate post-natal period and suggested that these experiences are complex and contradictory. Women experience conflict between their actual experiences and their socially constructed expectations of motherhood, and between the social construction of their identity as good and fulfilled mothers and their actual loss of their autonomous identity as individuals (Nicolson, 1988). The difficulties of motherhood do not get any less with second or later children, since having additional children involves a process of adjustment to the added problems of childcare (Nicolson, 1988). Gavron (1966) identified the experience of mothering as problematic and Boulton (1983) found that women's experiences as mothers of young children (children up to five years old) were problematic and contradictory.

The transition to motherhood involves a loss of autonomy and personal identity, a sense of disappointment, loss and grief (Nicolson, 1988). Far from experiencing motherhood as a confirmation of her identity, a woman may experience it as a loss of identity since

she becomes defined solely as a mother, and as a source of grief since the reality of the experience does not fulfil her expectations (Nicolson, 1988, 1992).

The experience of motherhood can be explained in terms of gender identity. The social construction of motherhood is incorporated into gender identity, and affects all women whether or not they are mothers. Approaches which neglect the social context of women's experiences and the importance of gender as a social construction, neglect important aspects of female experience. For example Smith (1990), does not directly consider the question of gender, but looks at motherhood in terms of individual adjustment and movement through a life stage. This ignores the question of how the social construction of motherhood defines women's expectations and identity throughout their lives.

PART III ISSUES FOR RESEARCH

1. Motherhood and subjectivity.

Motherhood is central to women's identity and experiences of self. Using a Meadian analysis, it can be understood as an experience of self, and of a self which is formed, incorporated and reflected upon through social interaction. But motherhood can also be distinguished from other experiences, as an experience which is central to the construction of female gender identity, whether or not a woman has children. As subjectivity, it can be conceptualised in terms of an on-going experience of self, a constantly developing and changing sense of self. It can also be conceptualised as a social and interactive experience which is given meaning through the incorporation of social constructions of motherhood, within relationships and through the woman's reflection upon her own experience. Women do not simply react to the experience of motherhood but they actively reflect upon it and it has meaning for them. Motherhood can thus be understood as a variable and contradictory experience which is on-going and meaningful throughout a woman's life, and whose meaning depends not just upon her experience as a mother but upon her experience as childless woman, upon her incorporation of the idea of motherhood as part of her female identity, upon her expectations of motherhood and upon her reflections upon the social ideology surrounding motherhood.

Nicolson (1988) investigated women's experiences of depression in the twelve month post-natal period, in terms of the meaning of those experiences to them, drawing on the work of Mead (1934) and using Giddens' (1979) concept of durée (see Chapter Three, Part II, sections 2 and 3) to look at the meaning of motherhood as dynamic, as on-going and as constructed at a particular point in a woman's life. Using a longitudinal case study approach, she suggested that common themes could be identified in the variable experiences of the women she interviewed. These included experiences of grief and loss as women adjusted to their new identities and roles as mothers, as they experienced feelings of loss for their past selves and disappointment in their expectations of themselves as mothers, and as they experienced feelings of inadequacy as they failed to match up to their expectations of themselves as mothers.

Nicolson's (1988) approach focused on women's experiences of motherhood as problematic, and showed how the social construction of motherhood and the ideology surrounding motherhood is powerful in women's interpretations of their experiences. Nicolson (1992) also demonstrated that women were ambivalent in calling their experiences "depression" and that this ambivalence centred around their rejection of the label as pathologising, given their own understandings of their experiences as

problematic. However, while the label of depression was inappropriate it was also the only available powerful discourse with which women could legitimate their problematic experiences (Nicolson, 1992).

The approach pursued in the research reported here (Study IV, Chapter Eight) draws on Nicolson's (1988) work in looking at women's experiences as mothers of children under school age. However, the aims and questions addressed in this research are distinct from Nicolson's work and specifically:

1. The research reported here investigates women's experiences of depression but not specifically in the post-natal period. It is not specifically concerned with the concept of post-natal depression.
2. The research reported here aims to investigate how women themselves understand their experiences of depression rather than to challenge the validity of the concept of depression as applied to women's experiences, whereas Nicolson was concerned with the validity of the concept of post-natal depression.
3. Study IV (Chapter Eight) investigates women's experiences as mothers of young children, and seeks to identify what is distressing about their experiences as mothers and how experiences of motherhood are incorporated into women's experiences of depression.

2. Summary and issues for research

Women may experience a loss of self in motherhood (Nicolson, 1988), which can be understood in terms of loss of role and identity (Oatley and Bolton, 1985). However, whereas Oatley and Bolton (1985) suggest that loss of a role is directly linked to loss of self and so causes depression, they do not consider the complexity of individuals' experiences in roles nor how the self is constructed through role relationships. They give no consideration to the questions of how a role is valued, why some roles but not others are central to one's sense of self, and how social identity is constructed. They ignore the issue of gender, its incorporation into sense of self and the experience of gender identity through gender appropriate roles. The research in Study IV (Chapter Eight) attempts to deal with these issues through developing a symbolic interactionist perspective, in order to explain women's experiences of depression as mothers

Motherhood can be understood as incorporated into the construction of femininity and gender identity, as a natural experience for women. As such it is constructed as a fulfilling experience, one which is non-problematic. This presents problems for women when they do experience motherhood as problematic, since problems may then be attributed to the woman's personal inadequacy.

In Study IV (Chapter Eight), a symbolic interactionist perspective (Mead, 1934; Blumer, 1969) is developed through the analysis of women's subjective accounts of their experiences of motherhood, and is drawn upon in explaining women's experiences of depression as mothers. A symbolic interactionist perspective is relevant to answering some of the problems identified above, particularly in Oatley and Bolton's (1985) study. Oatley and Bolton (1985) draw upon symbolic interactionism, but they do not pursue its implications for the construction of gender identity and the incorporation of gender identity into self (see Chapter One, Part II, section 4). For example, a woman's identity as a mother may be constructed through interpersonal relationships and may incorporate powerful social ideologies of womanhood and motherhood. Furthermore, the ideal of motherhood is analogous to Mead's (1934) concept of the "generalised other", through which the ideal of motherhood becomes the "other" against which women assess their own experience. Thus women may be seen and see themselves as defective and inadequate mothers, without questioning their assumptions and expectations of motherhood.

CHAPTER EIGHT: STUDY IV GENDER, IDENTITY AND DEPRESSION: EXPERIENCES OF MOTHERHOOD AND DEPRESSION

INTRODUCTION

In this chapter, Study IV is presented and discussed, an interview study with women who were mothers about their experiences of motherhood and depression. The literature pertaining to this area has been reviewed in the preceding chapter.

The aim of Study IV, as of Study II, was to examine the complexity of subjective experiences of depression. The study is thus a development of research issues identified earlier and builds on that research. Study IV also arose from an interest in looking at how depression is experienced by women as part of everyday life and in looking at when and how women identify subjective experiences as problems of depression. The question of when experiences are interpreted as depression draws upon previous research in this thesis, since it involves looking at the use of socially constructed notions of depression and, in particular, at the use of the medical discourse of depression as pathology and at the construction of alternative discourses to the medical discourse. (See Study I and Study II in particular).

Study IV focuses on gender issues and on the social construction of gender identity as incorporated into subjective experiences of depression. In Chapter Seven, the literature pertaining to the higher prevalence rates of depression among women than men was discussed, and it was noted that the issue of gender has not been adequately addressed in terms of what women subjectively experience as depression. It was also argued in Chapter Seven that the relationship between experiences of self, social constructions of gender identity and the construction and experience of gender appropriate roles has not been sufficiently theorised. It was argued that symbolic interactionism (Mead, 1934; Blumer, 1969) offered a potentially useful theoretical perspective.

Study IV focuses on women's experiences of depression as mothers. Mothers of young children are vulnerable to depression (Brown, Ni Brolchain and Harris, 1975; Perlin and Johnson, 1977; Radloff, 1975), and motherhood is also central to the construction of adult female gender identity (see Chapter Seven). Study IV investigates the relationships between women's experiences of motherhood and their experiences of depression, and between their identity as women and mothers and their experiences and constructions of self. This is done through analysis of women's subjective accounts of

their experiences, and includes looking at how women themselves make sense of their experiences of motherhood and depression.

PART I DESIGN AND METHODOLOGY

Aims of the study

Overall aim: to investigate subjective experiences of depression among women who are mothers,
and to look at the role of gender in the construction of self, identity and experiences of depression.

Specifically:

1. To investigate how participants understand the concept of depression:
   a. to examine the meaning of the term "depression" as used in their accounts
   b. to investigate what experiences they identify as depression
   c. to investigate when and how they use the term "depression".

2. To investigate what is depressing about being a mother and the experience of motherhood:
   a. to investigate what women subjectively experience in their lives as mothers
   b. to investigate the meanings of their experiences for them
   c. to identify common themes in experiences of motherhood.

3. To investigate motherhood as an experience of self and identity:
   a. to investigate how a woman's identity as a mother is constructed
   b. to investigate how women's expectations of motherhood influence their experiences of themselves as mothers
   c. to investigate how a woman's experience of herself as a mother is related to her experiences of depression.

The study was initially designed to mirror the patients' and clinicians' studies in looking at subjective experiences of depression among those receiving help, and to look at how helpers approached the problem of depression.

Design, recruitment and procedure

Sample criteria

Women who had young children (under school age), were full-time mothers and were experiencing distress were to be interviewed. Volunteers who provided support to

distressed mothers were included, in order to provide another perspective on help-giving to this population and on the experience of motherhood.

It was thought that the effect of a woman's role as a mother would be more easily identified among "full-time mothers". (This phrase is used here to mean mothers who had no paid employment outside the home, and not to imply that women who have paid employment are part-time mothers. Although a study of working mothers would also have been relevant to the aims of the study, that was outside the scope of this thesis, given time constraints).

Sample criteria did not include consideration of women's clinical status (whether a woman was diagnosed as depressed or not) since the aim was to look at their experiences as mothers. Women who had been receiving medical care were not, however, excluded. Also, seeking medical care was potentially an important aspect of the experiences of mothers with young children, which might be incorporated into their understandings of depression.

Recruitment procedure

Women were recruited through a non-statutory organisation providing social support for mothers of young children (children under five years old) who were experiencing distress. Two groups of women were recruited: mothers receiving support from the volunteer organisation, and volunteers from the same organisation (not necessarily those volunteers supporting the mothers interviewed).

This non-statutory organisation supported mothers through volunteers who visited them at home as befrienders, or through organising support groups with crèches which provided the opportunity for mothers experiencing difficulties to meet. The women had usually been identified by their health visitors as in need of support and put in touch with the organisation, (one of the mothers interviewed had referred herself, but this was unusual).

The sample was recruited in two ways:

1) To arrange the interviews of the women interviewed at home (this included volunteers and mothers), a worker for the voluntary organisation initially contacted women whom she thought would be interested in taking part. She told these women that a university researcher in psychology was interested in interviewing them about their experiences of motherhood and depression and then, if they were interested in finding out more about the study, passed their telephone numbers to me. I then

telephoned interested women, told them that I was a university research psychologist and outlined my interest in interviewing them about their understandings and experiences of depression. I emphasised that the interview would be informal, anonymous and confidential, and that it would be tape recorded. All prospective participants agreed to take part in the study. A time for the interview was then arranged with each woman.

2) Alternatively, women were interviewed at a support group. This group was a joint venture between the voluntary organisation and a local general practice. It was staffed by two health visitors and a community psychiatric nurse from the general practice, and volunteer crèche workers and a cook from the voluntary organisation. (I had interviewed the health visitors and the community psychiatric nurse as health professionals in Study III). The group had just been set up and I became involved in interviewing during the first month of its running. The general practice was in a mixed area, with some middle-class mothers but with a high proportion of working-class mothers and single mothers, and with mixed housing, from hostels to some very pleasant detached housing. The purpose of the group was to bring together mothers within the practice area who were isolated and were relatively unsupported, including a large number of single mothers, in order to provide a forum for them to meet and develop networks of social support.

For the purposes of this study, the support group provided access to a large number of women whom the health visitors and the worker for the volunteer organisation considered were potential participants. Of practical importance, the crèche and the availability of a private room meant that the interviews would be relatively undisturbed.

I visited the group over a period of four weeks (it met one day per week). The health visitors introduced me to individual women whom they considered potential, interested participants, according to the criteria set out above. However, a few women began to approach me or the organisers of the group directly to ask about the study, after initial interviews had taken place with their friends or others in the group.

As outlined above in relation to women interviewed at home and contacted by telephone, I explained individually to women at the group that I was a research psychologist at the university and outlined my interest in interviewing them about their understandings and experiences of motherhood and depression. I emphasised that the interview would be informal, anonymous and confidential, and that it would be tape recorded. All women approached were willing to take part in the study and were interviewed soon after the initial introduction.

Participant characteristics.

18 women were interviewed. 1 was a full-time volunteer organiser, 5 were volunteers working for the organisation in supporting and befriending mothers who were experiencing problems (referred to as "volunteers"), and 12 were mothers of young children and were receiving support (referred to as "mothers"). The 5 volunteers were interviewed at home and the full-time volunteer organiser in the Department of Psychology at the University. Of the mothers receiving support, 7 were interviewed at the lunch time support group and 5 were interviewed at home.

Broad biographical outlines are given in order to give an outline of the sample without providing detailed information about each woman, in the interests of confidentiality and since more details emerge as they pertain to the interview analysis. Pseudonyms are given for women who are quoted in the interview analysis.

10 of the 12 "mothers" interviewed were in their twenties, one was in her forties and one was in her early thirties. They were mostly poorly educated, except the woman in her thirties (Ros) who had received higher education. They all had one child (including Cate, Ann and Hilary) or two children (including Ros, Penny, Beatrice and Fran) under five. Two of the women were married (including Penny and Cate) and three were in long-term relationships (including Fran, Hilary and Ros), although of these only Ros did not describe her relationship as very uncertain. The other women were single mothers. Their housing ranged from hostel accommodation (Beatrice) to rented houses and flats in working-class areas.

All the volunteers and the full-time organiser had children who had either grown up and had left home or were teenagers still at school. One of the volunteers had herself been a single mother. One had university education and another professional training (Jean). All could be described as middle-class. None was currently in full-time employment. With the exception of the single mother, all the volunteers were married to the fathers of their children. The age range was from early forties to early sixties, with four women being in their forties, one in her fifties and one in her sixties. They had worked as volunteers for up to four years, and for a minimum of one year.

Interview design

The same interview design was used as in the study of patients, Study II (see Chapter Five, Part I). At the start of interviewing the schedule used in Study II with patients (see Appendix C) was used for interviewing the mothers. Through the process of

interviewing, this was developed into a distinct schedule for the mothers (see Appendix E), to focus on and incorporate issues which emerged from earlier interviews in Study IV. A schedule for the volunteers (see Appendix F) was similarly developed, adapting and developing the interview schedule used in interviewing health professionals in Study III (see Appendix D).

As in the studies previously reported here, schedules were used for prompting but the aim of the interviews was to investigate what participants themselves saw as important (see Chapters Two, Five and Six).

Interview procedure

All women were interviewed individually and interviews lasted from twenty to ninety minutes.

Interviews proceeded in the three stages outlined in studies reported earlier: warming up, the main body of the interview and winding down. (Further details are given in Chapter Two, Part I.)

The interviews were mostly self-generating in that after the initial introductions, and as the interview developed, participants talked freely about their experiences. There were two exceptions to this, when it was difficult to achieve any rapport with the participants (Beatrice and Ann) and the direction of the interview then depended on more direct questioning by the interviewer, though this questioning was directed to clarify, and to encourage the participant to elaborate upon, previous statements.

Transcription

All interviews were transcribed verbatim, as in earlier studies reported here. More details about transcription are given in Appendix B.

Data analysis.

More details about the mechanics of the data analysis are given in Appendix B.

The significance of this study within the development of methodology in the thesis.

This study of women's experiences of depression is wider in scope than previous studies presented in this thesis. It investigates mothers' experiences of depression, and this included their experiences as mothers, as possible patients, as women and in all areas of their lives which they considered relevant. The accounts could be understood only through reference to wider social and interpersonal issues which were contained within them, and this served to highlight the complexity and inter-relatedness of

experiences of gender, motherhood and depression. For example, the data indicated that there was an interchangeability in the experiences of motherhood and of depression, but this did not narrow the focus of the analysis. It became clear that meanings of both depression and motherhood were structured at both a societal level and an interpersonal level and that these levels of meaning were interrelated, and were drawn upon at an individual level in the subjective interpretation of experience.

In the interview studies with patients (Study II) and clinicians (Study III) there had been a particular focus of analysis which was chosen as emerging from initial stages in the analytic process: the importance and meaning of a medical discourse of depression in interpretations of experiences of depression. *In this study, the concern was to keep track of the complexity of accounts as a whole, and this represents a development from the approaches of earlier studies.*

Aims in the analysis

The analysis involved making the implicit, explicit (Henwood and Pidgeon, 1994). Relations between themes and within and between accounts were often implicit rather than explicit, especially given the different qualities and ranges of accounts. Through deconstructing the terms within which a woman accounted for her experiences, hidden knowledge could be made clearer and linkages could be recognised. This involved looking both at the content of the experiences a woman described and at the discourses available to her, as shown within the account, to interpret and discursively construct these experiences as conscious knowledge.

For example, women gave apparently contradictory accounts of experiences of motherhood, both as loss and as purposeful and meaningful. The contents of experiences of motherhood described were different and variable, sometimes experiences were enjoyable and sometimes not. However, the discourses used in constructing accounts were limited and the social construction of motherhood was of it being fulfilling. The significance for women of this contradiction could be addressed through identifying both the content and discursive construction of experiences. Contradiction was an important feature of women's experiences and knowledge, and of their interpretations of themselves and of their identities as mothers. Contradictions in experiences which could not be contained within social discursive practice could lead women to identify themselves within the terms of this practice as poor or inadequate mothers. Accounts of experiences which were at least sometimes difficult and frustrating were common, but women constructed themselves as failures and suppressed their knowledge of motherhood as in itself a difficult experience. A contradiction could

be identified between the simplified, one dimensional, social discursive construction of motherhood and the variable content of experiences.

The women's accounts were rich, variable and complex. They contained descriptions, interpretations and explanations of their experiences. The analysis attempted to do justice to the richness of the data, and its complexity and variability. The focus of analysis is on the women's own explanations and interpretations of their experiences, and what they identify as their sources of knowledge about depression and motherhood. There were differences between the types of accounts presented by individual women. Some themes emerged more strongly than others throughout interviews or in particular interviews, some women ranged more widely in their accounts, some focused on particular issues more, and some were more reflexive. The aim in the research process was to use all the interviews to inform the research presented in the thesis and in deciding the issues the research account was to focus on, although some interviews were drawn upon more than others in the research account.

The aim has been to develop an interpretative account of the data but as has been said, above, this is not a complete analysis of the data. The aim of the analysis, given the nature of this data, was not to construct links between features identified in the data but to recognise and identify the links already in the accounts, which the women themselves had made in giving meaning to their experiences. The task of the analysis was more, not less, difficult because of the complexity of the data and because of the richness of the many analytical points contained within the data. For example, there were complex, interlocked discourses used in reference to, and definition of, gender, motherhood and depression. The choice of what to focus upon was therefore problematic, since no analysis could be exhaustive nor comprehensive. However, this study has been approached as an exploratory study drawing attention to issues which suggest scope for further research.

For example, reflective observations within one woman's account might illuminate an interpretative point or the significance of experiences within other women's accounts, and what was significant in the analytic process was the validity of the potential link, and whether it helped to make sense of and could be validated within other women's accounts. Linkages could also be seen while observing the differences between accounts: women may have had similar experiences and interpret these experiences differently and these differences were themselves illuminating of how meaning can be structured and experience interpreted.

Method of analysis.

The method of analysis is described in terms of phases of analysis, as in the interview study with health professionals (Study III, see Chapter Six). As argued there, this process was recursive, so although broad phases can be identified, distinct stages are not implied. The methodology also developed on an evolutionary basis, as different approaches to analysis were taken in order to look at the data from different perspectives, and as further phases of analysis emerged from previous phases.

Phase 1 Within interview analysis

All transcripts were read repeatedly and detailed notes were made of each interview, to build up a picture of each woman's experiences and the ways in which she had understood and constructed them within the interview. This was a long and complex process involving repeated reading of the interviews and the development of themes on a within interview basis, using excerpts from the transcripts. At this level, the analysis was mainly descriptive. Two emerging issues were:

a) It became clear that experiences were structured in very different ways for individual women. For example, Ann and Jean explained depression as an illness and pathology, using medical discourses, and had long-term experience as medical patients, whereas Penny's interview was more exclusively concerned with her daily experiences and her reflections on life events over the past three years.

b) Some interviews were more wide-ranging than others and the nature of the data within some interviews was more complex, with many different themes emerging. For example, while Ann focused on her experiences of manic depression and her experiences as a patient, Jean saw her experiences in medical terms and also focused on her daily and social experiences and life history in a more biographical approach, which emphasised interpersonal and social aspects.

It was important to identify links between the themes as they emerged within the interview and, by focusing on these links between themes, to attempt to see how a woman developed themes in accounting for her experiences. The approach was to see the interview as a web, looking at the relations between themes, and to see the interview as a whole in an attempt to build up a more complex picture of the woman's understanding. This was a complex and time consuming process.

While the presentation of case studies would have been useful for a fuller analysis of the meanings of experiences to individual women, this was prevented in this thesis by space and time constraints . (See also Chapter Ten, Part III, Part B).

Phase 2 The identification of themes across interviews.
It was evident that some emergent themes were common across interviews, although the particular context and development of themes within interviews were variable. It was important to recognise the commonality of experience and to build up an analysis which recognised the construction of meaning as both a social and individual process.

In this phase of analysis, the interviews were placed in the two groups, of mothers receiving support and volunteer helpers, following the initial design of the study. An across interview analysis was attempted using the notes made on each interview within each group.

Initial cross-interview analysis proceeded by identifying important themes within interviews and looking at the ways in which these were used in other interviews, in an attempt to build up new themes and identify links between existing themes. Given the complexity of the data, themes were restructured at an across interview level while focusing on the initial themes identified within interviews.

The analysis was problematic given the variability of themes within interviews and given that themes were interlinked in different ways in each interview. Thus, although all the interviews drew on experiences of motherhood as depressing, women differed as to the extent to which and how they reflected upon their experiences: whether they saw themselves as poor mothers, whether they saw motherhood as a social construction, how politically and socially informed their approaches were, and the meaning of individual experiences of motherhood. It appeared that this would mean losing some data that had been important on a within interview basis, while emphasising the commonality of themes.

Phase 3 In-depth analysis of structured themes identified across interviews: thematic analysis.
It became evident that the commonality of experience between women in the two groups, of mothers receiving help and supporters, overrode the distinctions between these groups. Four of the five women who were volunteers had themselves experienced depression and consulted their G.P.'s about this (Tina, Jean, Kim and Enid) and women who were volunteers referred to their own experiences of motherhood in their interviews. Therefore in this phase the themes from the two groups, of mothers receiving support and volunteers giving support, were combined.

Common issues and themes in the groups' experiences as women and as mothers were emergent in the across interview analysis, in phase 2 above. These included experiences of interpersonal relationships; their expectations of, preparation for and knowledge of motherhood, mothering and childcare; the construction of a woman's identity as a mother; and the construction of experiences as "depression".

However, there was also considerable variability in the ways in which individual women constructed and used themes, and linked themes in their individual accounts. This had become evident in phase 1 of the analysis. The aim in phase 3 of the analysis was to focus on both the commonality of themes between accounts, and the variability of those themes as they were constructed and used in relation to other themes within accounts. In order to achieve these aims of identifying commonality and variability, and in order to attempt to encompass the range, variability and depth of the data, analyses at both a between interview level (phase 2) and within interview level (phase 1) were drawn upon.

For this purpose selected interviews were used, where themes were particularly marked and strongly developed, and where women had been particularly articulate, and which incorporated the greatest possible range of themes. This enabled a more in-depth analysis of themes as developed within and between interviews. This enabled the researcher to draw on all interviews in presenting the research account, while also showing some continuity between and within interviews.

As discussed in Chapter Five the concepts and methods of grounded theory were important at this stage (Glaser and Strauss, 1967; Strauss and Corbin, 1990; Henwood and Pidgeon, 1994). The grounded theory approach to categorisation, and the linking of categories, increases the manageability of the data and facilitates a move away from a more detailed, descriptive level of analysis. This is analogous to my approach to the identification of themes, identifying the links between themes and regrouping and relabelling themes. It was important in operationalising and recognising a move in my analysis from a more descriptive to a theoretically driven level of analysis. Reflection on the results of my analysis so far, which was also informed by reading of literature, particularly concerning women's experiences of motherhood, facilitated a more theoretical level of analysis in a further pass through the data.

Presentation of the research account

The research account presented here was developed in phase 3 of the analysis but, as discussed above, was informed by and incorporated earlier stages of analysis.

The aim in writing up this research account has been to show how complex the experience of depression is for individuals, that depression is constructed through their life experiences at many different levels, and that it has variable meanings which change over time, social context and within the interview.

Excerpts are presented to illustrate themes and to demonstrate how themes are structured and used in an individual account and throughout other accounts. 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 to draw attention to commonalities and variabilities in the data, as presented within the excerpts. Excerpts are presented as examples of themes and as such are representative. Excerpts do not represent all the various ways in which a theme might be used but attempt to show the significance of themes within women's accounts of their experiences. The excerpts show the women's own reflexive awareness of their experiences, and the ways in which they themselves have interpreted their experiences. They are presented in order to show this and to present the women interviewed as, in many cases, psychologists themselves.

Theoretical issues in the analysis

Initial readings of the interview data and analysis had suggested that experiences were interpreted and meanings were constructed at individual, interpersonal and societal levels, and that these levels of knowledge and experience were interlinked and evident to different degrees in the ways in which women interpreted their experiences.

This suggested that a framework of analysis which took account of and made evident the different levels of experience and knowledge of individual women, would facilitate an account of both the commonality and diversity of their experiences, looking at the related questions of: what their experiences were; how individual women constructed and interpreted their experiences; and what common knowledge women drew upon in formulating subjective accounts of experience.

Levels of knowledge and experience. Knowledge and experience can be approached at three levels in the structure of individual accounts: individual, interpersonal and societal. These are interlinked. The societal level includes a consideration of social ideologies, and the social construction of gender, motherhood, and depression, and the ways in which individual women use these in interpreting their own experiences. The interpersonal level includes the women's experiences of relationships and involves a consideration of how knowledge and identity are constructed in relationships. The individual level includes the ways in which individuals interpret their experiences and includes a consideration of issues of reflexivity (see Chapter Three, Part II, section 3) and the discursive construction of knowledge as conscious and unconscious (see Chapter Three, Part II, section 4.3).

Meaning and the concept of durée. The subjective interpretation of experiences can be understood as the product of a woman's particular experiences and her biographical position. This can be understood through Anthony Giddens' concept of "durée". The concept of durée takes into account the individual's particular social position as well as their point in their life history and the interaction between these. The concept of durée suggests that identity and meaning are ongoing processes which evolve over time and are dynamic not fixed. The concept of durée emphasises how individuals' interpretations of their experiences change over time and how past experiences are dynamically reinterpreted: meaning is dynamic not static, and is a variable not a unitary concept. The way a woman interprets her experiences depends upon the particular point in her life from which she is reflecting upon them. In interviews, women contextualised their experiences of depression as related to a particular point in their life history, and explained them with reference to their past lives and current experiences.

Reflexivity . Women interviewed were not simply the victims of their circumstances. In accounts, they actively interpreted their experiences. Their awareness and thoughts about what was happening were incorporated into their experiences of their lives as depressing. For example, their disappointed expectations that motherhood was going to change their lives, and their sense of hopelessness that anything was going to change, were part of their experiences of depression. They did not account for depression simply in terms of their descriptions of motherhood as hard work and isolated. Reflexive processes were thus identified as critical in the production of accounts.

Commonality and variability . There was commonality and variability (as distinct from variation) between and within accounts, both in what women interviewed had experienced and the ways in which experiences were interpreted and accounted for. There were commonalities in the ways in which women talked about their experiences as well as variability between and within accounts. Accounts suggested:

1. That depression is an individualised experience, as described by participants. But common themes in experiences of depression were identified across interview accounts. Depression is a common experience but not a shared experience.
2. That the experience of depression can be understood at a social, an interpersonal and an individual level. A combination of experiences, social and interpersonal and individual, are involved in depression, and depression can be seen as constructed at all three levels, as individuals understand themselves as failing at these levels. Depression is a common problem, but has a subjective meaning at an individual level.

PART II RESULTS

Introduction to the data analysis

The analysis of the data is presented in three sections.

PART A Identity and interpersonal relationships.

Part A will focus on women's experiences in relationships with others, and in particular on the construction of identity at an interpersonal level. This will also include a consideration of the social construction of female identity, in relation to the ways in which women experience their identities as individuals in relationships.

PART B Women's experiences of motherhood.

Part B will focus on women's accounts of their experiences of motherhood, and on the interpretation and construction of these experiences at an individual level, as seen in interviews. It will focus on participants' reflection upon, and use of, socially constructed notions of motherhood in relation to their expectations and evaluation of their experiences.

PART C The construction of "depression".

Part C will focus upon participants' use of the term "depression", the meaning of the term "depression", and attempts at constructing alternative discourses which avoid the medicalisation and pathologisation implicit in the term "depression". It will focus upon the ways in which women account for, construct and interpret their experiences as depression, and it will explore processes of reflexivity. It will be argued that the failure to construct an alternative discourse leaves women trapped between two positions: the recognition of problems as medical and pathological, or the internalisation of problems in a discourse of self-blame and inadequacy. It is suggested that there are no powerful discourses available which validate women's experiences as problematic and that it is difficult for women to obtain help through available institutions and processes, including the medical system. While the problematic experiences of women interviewed can be interpreted as societal, they are experienced at an individual and interpersonal level, and the meaning of experience is constructed at all three levels.

PART A : IDENTITY AND INTERPERSONAL RELATIONSHIPS

1. Motherhood and the loss of autonomous identity

Margaret, a full-time worker for the organisation, suggested that one of the main problems in her experience of motherhood was loss of identity, since in motherhood a woman loses her autonomy and personal identity and is exclusively defined as a mother by others.

Margaret believed women were identified as mothers in their relationships with others, and themselves took on the identity given to them. She suggests that women themselves lose their own sense of who they are:

> Marg: Yes. Yes. I mean, it's um, the main thing, for me and I think most mums, is the loss of identity. You stop being who you are. You stop being Janet or Margaret or Louise and you become um, Sally or ...'s mum or somebody's wife. That you stop being who you were. And when people ring up they always say, "Are you so and so's mum?". And, but we do it as well, to other people. We take away people's identity as well when you become a mum. Everything is based round the children. And it's, you might have been, um, still have been a person in your own right when, before you had the children, even if you'd got a partner, ... married or not. But all of a sudden that seems to go totally as well, once you've got a child. Um, and it's very difficult then because who are you and what are you? It's er, it's a really, it's soul destroying. And it, for some people they're not always aware of it.

Any autonomous identity which the woman previously had is lost and she is identified only in terms of her children. She is reduced to her function as their mother. This loss of a personal and autonomous identity is unique to motherhood; women are not usually identified exclusively in terms of their relationships with their partners for example. (One example of a group of women who are identified in terms of their relationships with their partner is the wives of vicars. See the example of Jean, section 2.4 below. See also Finch, 1983).

This loss of identity is accomplished through relationships which now focus on the woman's role as a mother. It may be an unconscious process, both for others and for the woman herself, and as such reflects and reinforces social values and the centrality of motherhood to a female identity. A woman's identity is defined by others and is internalised by the woman.

Margaret suggests that, on becoming mothers, women may experience a sudden change and loss of identity which they are not prepared for, and which leaves them confused. Part of the problem is that women are not always aware of what is happening to them

and this leaves them less able to cope. While a woman may anticipate a change of identity in motherhood, this is popularly understood as a gain and an enhancement of identity. There is little recognition of the loss of identity which women may experience in motherhood.

Margaret suggested that the transition to the exclusive identity of a mother begins in pregnancy and that medical personnel are initially particularly responsible. Women are called "Mum", and they may see this as an enhancement of identity, a confirmation of gain in their status, and be unaware of the implied loss of their personal identity, as they lose even their own names. This may be an unconscious process, as the woman herself and others are unaware of the change in identity they are affecting. But it reflects and reinforces the construction of female gender identity in terms of biological and reproductive function.

Marg: Sometimes it starts before um, you actually have a baby. Sometimes, especially in the clinics, the consultants and the nurses will say, "Oh, hi Mum". So in fact, and they don't realise what they're doing. And, in fact, when you, especially with the first baby you feel so proud that you don't realise that that's the start of the slippery slope to no identity of your own. But doctors and nurses are some of the worse culprits for not addressing people by their names.

In retrospect, Margaret recognised that she had lost her identity. Paradoxically, it may be that the gradual loss of her own identity means that a woman is less aware of that loss and it is only later, when she has regained some sense of self, that she is able to reflect upon it.

Marg: Um, at first, but um, but after a while it um, it starts to, to - trying to think of the phrase - I'm not saying that you'd notice it but it starts to be an annoyance that you're always called somebody's mum or - the same with - and not everybody realises that they aren't whoever they were before.
Siân: Yes.
Marg: It's only, kind of, later on that you sit back and look at it and think, "That's why I felt like I did. That I wasn't a person in my own right any more".

2. Validation of women as mothers

2.1 Legitimating the role of a mother

Accounts suggested that women may lose any sense of their own importance when they become mothers. Margaret, in reflecting retrospectively on her experience of motherhood, said that the reaction of her G.P., who took her concerns seriously, gave her self-respect. She no longer felt marginalised as a mother.

Marg: And from being down I actually - my shoulders went back, my head went up and I actually felt great because he was assuming that I'd got a right to feel like that, that I'd got a right to worry and everything. And I can still remember how I felt, that it was like a huge weight lifted off my shoulders - that he was validating my role as a mother and that mother had a right to feel worried and everything and that he took me seriously. And it was absolutely wonderful.

While a woman's reproductive potential may be important in pregnancy, she herself may cease to be so important after childbirth. Penny was aware that she had ceased to be important after the birth, when visitors attended to the baby but not to her, but she tried to suppress this knowledge. While at one level she was aware of her loss of importance since becoming a mother, at another she chose not to reflect upon it.

Penny: When I had our Julie and people were visiting it all'us felt as if they'd, you know, just come to see her and not - you know, and not you very much.
Siân: Because that must be difficult.
Penny: Yes. You try to push it to the back of your mind and just - you know - think you don't feel like that but it does feel a little bit.

Tina explained that she was interested in working as a volunteer because her own role as a full-time mother diminished as her children grew up. She enjoyed working with young children, and added that she was at their level, in a joking but self-derogatory phrase which implied that she had little sense of her own worth, or her abilities and her skills as a mother.

Tina: The motivation for voluntary work was the fact that my children were growing up, I wasn't going to get a job, and so I was going to have an awful lot of time on my hands, I was going into retirement as regards motherhood, and I thought, "I'm going to fill it". So I looked round for something that would appeal to me, and this sort of thing appealed because it dealt with young children, I like -, 'cause all the families have got under five's you see so I can quite happily mix in with them. - About my level!

2.2 Feeling worthless

The only source of recognition for some women interviewed, such as Cate, was the recognition they gave themselves, that they were doing a difficult and worthwhile job. This is frequently not enough and is difficult to maintain. A woman may not only lose any time for herself but also receive no recognition that she is achieving anything in her time with her children.

Cate: You feel like, drained. What's the point? You know, why am I doing this, I get nothing back from it? I suppose you start feeling kind of worthless. Even though that, you know you're doing a good job trying to bring a child up, it's just like.

Diane, a volunteer, suggested that it may be that the work involved in parenting is not recognised as worthwhile because nothing is achieved which is tangible and easily measured or recognised. The achievement of parenting may not be compatible with societal ideas about what is worthwhile and what is recognised as worthwhile: it is gradual, long-term, and has no easily identifiable targets nor results. Parenting is an evolving relationship between the child and the parent which cannot be reduced to individualised measures of achievement. For Diane, the satisfaction lay in participation in the process of parenting, but the process of parenting is not easily recognised by other people as an achievement.

Diane: Expectations are very high and I think sometimes, you know, when you're bringing up children at the end of a day you probably don't see what, what, if you like to, sort of, look back on the day and say, "Well what have I done today?", you probably haven't done an awful lot apart from, sort of, wiping up spills and, sort of, put out a few paint pots or done a jigsaw. I mean, there's often nothing terribly constructive... You know, you can't measure it. It's not, you know, you can't put it into a neat and tidy compartment and say, "Well, I've achieved that today"... And that's what's difficult.

Siân: Yes. And do other people value this?

Diane: I think, I think, well this is it. I think people need to be re-educated. I mean, some people do obviously realise that, you know, despite all this that they have, you know, the fact that the children are happily, you know, happily getting on with things and so on, you know, it's been a good day if they look for the right things. But um, it is difficult to measure it... And we, I suppose we're geared to, sort of, having instant rewards and um, things measured and so on, and it's not like that.

2.3 The good wife and mother

Interviews suggested that women may see themselves as failures because they have failed to fulfil the functions of their roles as a wife and mother as defined by their partners. However, they are not free to simply reject these roles, since these roles may be primary in their sense of identity. It may then be that it is only through the valid fulfilment of these roles that they can experience a valid sense of self.

For example, Hilary related her experiences of depression to her husband's definition of her as a failure as a wife and mother. She claimed she had internalised this definition and now felt powerless and incapable. Recognition of her success in marriage and as a mother was vital to her experience of herself as acceptable.

Hilary: And now we're in the situation that I suppose I am depressed because my husband does a lot of psychological things to me, you know, he says I'm just rubbish and I'm not a good wife, I'm not a good mother, and he says this to me all the time and it's just really hard to cope with and he's with that -. And I find it -, I feel... that no-one else will marry me, you know,

if I get divorced from him, no-one else will marry me and my family don't want me. So, I just -, it's really hard.

Siân: So it's like you've got nobody really.

Hilary: No. And he says I'm rubbish with children, you know, and I don't feel I can have any more children, you know if I get married again I feel that I can't have any more children, you know to another man, because I'm not very good at it, you know.

Siân: Who's told you that?

Hilary: It's him that keeps telling that, you know, I believe it myself now as well and -.

She is aware that there are other valuable aspects of her identity but she does not feel free to experience these. There is a contradiction between how she believes she is seen by others and how in the past she has experienced herself, which remains unresolved. She is most aware of her construction as a failed wife and mother in her relationship with her husband.

Hilary: Um, I don't really feel any respect because I just feel a failure, you know? I just, you know, I just feel that I've failed as a wife. You know, I can't be a wife or a mother.

Siân: Yes. Do you think - ?

Hilary: Then, maybe, you know, I could feel some sort of respect, you know, like I am still a person, you know, and I can still work and I still have intelligence, you know? And I still can do something you know. It's just, you know, the fact, like the wife and the mother bit that I can't - .

2.4 Guilt

Jean suggested that she could not cope with both her professional career as a teacher and her roles as a mother and a cleric's wife. As a result, she finished professional work and her role as a cleric's wife took precedence. Jean could not cope with the conflict presented between her own career and needs, and her role as her husband's wife, meeting the demands of his profession. She believes that what she was expected to do was impossible, but she judges herself as failing, in not fulfilling the impossible. While she may have recognised the "superwoman" as an impossible ideal, she may also have internalised this as an ideal against which she judges herself and hence cannot succeed.

Jean: I've always chosen to, to go where my husband goes so that limits the choice quite a bit.

Siân: So why both, I mean, both being a Minister's wife and being a school teacher, it seems like an awful lot is expected of you?

Jean: Mmmmm.

Siân: And you can't - .

Jean: No I couldn't. And I always felt guilty because, because I'm not superwoman, I couldn't do both jobs.

Siân: Yes.

Jean: As fully as I ought to do. And usually what I do is to decide which job I'm going to do the best.

Penny could not deal with the conflict between her roles in paid employment and as a mother. She was responsible for bringing in a major part of the family income as well as for care of her children. She found it emotionally difficult leaving her children and had not enjoyed her paid work. She was faced with a dilemma in reconciling her role as a full-time mother and her role as a wage earner. She felt guilty because she was unable to fulfil both roles. Despite the importance of her income in making mortgage payments to keep the family home, she experienced her role as an earner as conflicting with her role as a mother, rather than an alternative way of fulfilling that role. Thus her socialisation into womanhood and motherhood can be seen to constrain the roles and activities available to her, and may exclude her from seeing paid work as a valuable part of motherhood.

Penny: Mmmmmm. I mean, I had, after I had Joseph I had to give work up, and we'd got us own house. But I thought if I didn't I'd end up in a, you know, mental place or summat like that because it tugs on your heart strings. I mean, you've got to go to work and yet you've got to leave them behind. And you feel somebody else is going to, you know, see their first steps and hear their first words and you're not. Then I just, you know, I couldn't cope with it... About £100 a week I were coming out with and I had to give it up. Just had to...

Penny faced a conflict between her own needs as an adult and her role and identity as a mother. For example, she felt guilty at wanting to get away from her children. Underlying her sense of guilt is the idea that a good mother should be self-sacrificing. Although she acknowledged her own need for adult conversation, which she could not have with the children present (and during the interview she was constantly having to pay attention to the children), she felt guilty because this was a need which she could only meet in opposition to her children's demands for her.

Penny: But then I think, just wanting to get away from - now, anyway it is - wanting to get away from these, wanting to go and - . I know it seems awful that but -
Siân: No it doesn't actually, it seems really sensible.
Penny: But, yeah, but adult conversation, just wanting to mix and be with people. You know, rather than just stuck in these four walls. It's that what drives you mad.

Penny explains her guilt as an inevitable part of being a woman, and as a validation of womanhood. This suggests socialisation into womanhood as meeting other people's needs. Here, womanhood implies an ideal of selflessness and that women's needs are met through meeting the needs of others. Penny resolves the conflict between her own and her children's needs by subsuming her own needs. Thus Penny legitimates the conflict and guilt she feels over her children as a validation of being a woman.

Siân: Yes. It's funny isn't it, how you have to feel kind of guilty about wanting to get away from it.
Penny: Mmmmm. Yeah.
Siân: But it really sounds like the most human -
Penny: Yeah. I don't think a woman would be a woman if you didn't feel guilty, you know, like that. Really with them.

3. Motherhood and the experience of powerlessness

The loss of identity, which women interviewed experienced, may reflect social constructions of gender. Female identity, defined in relation to motherhood, can be seen as one-dimensional and exclusive. By contrast, men as fathers may have an autonomous and multi-dimensional identity, independent of their function as fathers and defined in terms of their own achievements.

Ros was aware that her own family saw her, as a woman, merely and exclusively in terms of fertility and child bearing. She had struggled to find alternative ways of being a mother, which allowed her to be herself. These were not readily available.

Ros: Well, I'll try and put it briefly that they think, well, you know, because of the kind of family I have, people just have demeaning way of looking at women - well, women are for fertility, babies, you know, just all part of it and um, you know, I could have, if I hadn't had children, I wouldn't have had that lot, I could have stepped out of women's roles or... There's all quite a lot of misogyny tied up in that. Um, I just coped. I mean, I think, I suppose I did sort of gradually reassemble myself into society. I went to the local adult education group and did something just within the community.

Many interviews suggested that motherhood may be experienced as powerlessness, since women may lose any sense of themselves, of their individuality and of autonomy.

Marg: Men have every right to be so and so's father, er, and to be treated as such, er, and women have every right to have a role of their own. But they're not, they're not, it doesn't matter how good a career you've got once you're out of that office, put in a different situation you're still so and so's mum. Whereas the father will be Mr. So and So.
Siân: And even when you're in the office?
Marg: Yes. Yes. It can, unless you can totally detach yourself and make it totally separate, which some women have to. It's er, it's the most disempowering thing that can happen to a women is having children. You lose your total identity.

Margaret suggests that mothers who are employed as professionals may have more varied experiences but are faced with conflicting responsibilities, roles and identities. This is not a conflict which men face. The role of a mother may be constructed as exclusive and incompatible with other roles.

Marg: It doesn't matter how good a career you've got, once you're out of that office, put in a different situation you're still so and so's mum. Whereas the father will be Mr. So and So.
Siân: And even when you're in the office?
Marg: Yes. Yes. It can unless you can totally detach yourself and make it totally separate, which some women have to.

Diane, a volunteer who had stayed at home and worked as a full-time mother, considered herself fortunate in that she had not had to choose between a career and full-time motherhood.

Diane: Well yes, I mean, well mine are, sort of, in their twenties now - so well and truly, sort of, off, you know, off and away doing their own things. Yes, but there were times when it was, it wasn't easy. Definitely. But, yes I did enjoy it. I mean, I wanted to be at home and I wanted to be with my children and I didn't have all this agony about career and giving that up. Er, which I think is a pressure for a lot of people today.

4. Loss of potential autonomy

Participants' interviews suggested that women, on becoming mothers, may feel the loss of potential or actual autonomy and independence. This may occur as they discover that motherhood is not the ideal they had expected.

Beatrice had wanted a future of marriage and family life. (As she had herself been in and out of care as a child, this may also reflect her wishes for security and family relationships she had never had). However, she was living as a single mother in hostel accommodation and had a "partner" who visited her periodically.

Bea'ce: All I've ever wanted is an house with an husband and then kids. I got house and kids. Well I want a house. I've got kids.

She saw her female friends and peers as autonomous and independent, enjoying a freedom which she had never had but wanted. Her interview suggested that she was positioned between two conflicting ideals, the fulfilled mother and the independent woman. Through motherhood, she had lost her potential freedom and autonomy. Her experience of motherhood was not one of secure marriage and family life. It reinforced the loss of a freedom which she believes her friends now have.

Siân: If Joanne [her daughter] was like, now ten years older, what would you say to her about having children?
Bea'ce: Keep her legs crossed. I'd try and advise her not to until she's had a career or she's settled.
Siân: Yea. This also might sound like a silly question. Why is a career important?
Bea'ce: To achieve something.
Siân: Yea. Is it kind of independence?

Bea'ce: Yea, I suppose, yea. As it is I see all me friends now and they're all working, like all executives in offices and all rubbish, and see me with two kids walking round and they've done what I wanted to do. So now I've just got to try and do it myself.

Despite her dissatisfaction, she was pregnant with her third child. This may be explained as an investment in her continued if hopeless expectations of motherhood, or as hopelessness and the difficulty of envisaging an alternative future for herself. (She had said in the interview that she did not enjoy motherhood but appeared to feel hopeless about her chances of working and achieving some freedom and independence).

5. Loss of self

5.1 Marriage

Jean suggested that she experiences a loss of self as she is overwhelmed by the expectations of others. She experiences herself as a different person in different roles, but these roles are often defined through her relationship with her husband. She suggests that through her relationship with her husband she has experienced herself as subordinate to him in roles as his wife. Moreover, to fulfil these roles she has to give up her own role and identity as a school teacher. Her voluntary work now represents a chance to do something for herself rather than for him.

Jean: Yes. Er, I am a minister's wife so I am an appendage... In lots of my activities I'm standing in for him or I am assisting him or I am tailing along behind him... I am not myself. Erm, I was a professional person as a school teacher. I'm not that any more, though this is something for me, for [Vol. organisation] which has nothing to do with the rest of my life. Therefore, perhaps, I present a different person when I'm doing that.

Jean had worked as a housekeeper and had a sense of her own capability and autonomy in that role. She gave up her post to support her husband in the role of the minister's wife, but she did not enjoy this role nor feel capable in it. However, she suggests that she cannot choose to pursue her own interests in preference to filling the role of the minister's wife.

Jean: We lived in X before and um, I didn't teach there but I worked as a housekeeper for a family who ran their own business, and the wife needed a wife. So I acted as her wife and thoroughly enjoyed it. It was all in, it was in my, you know, domestic field, but again I couldn't cope with that and um, being 'the minister's wife' as they wanted it.

Jean feels that she has lost her sense of self through her marriage and that her true person has been repressed, that she experiences herself differently in different roles and that within her marriage she has lost her self. She suggests that she has been aware of

herself as a person who is not able to express herself within most of her social roles. She is aware of an alternative self, and distinguishes this potential self from her experiences in her everyday life and her marriage. Her voluntary work gives her an opportunity to experience herself in an alternative way. Her married role and identity excludes a truer experience of self.

She suggests that she can experience herself as a different person through her work as a volunteer, visiting mothers and their families:

> Jean: Nothing of what I am in that [her work as a volunteer] reflects onto the other people that I am. I don't talk about it because it's a, the work is um, done in confidence anyway, so it um, I mean, obviously, there is an overlap but in another sense there isn't an overlap. So, and I don't carry a surname with me... So my only identity is my Christian name. And your Christian name really is your person isn't it?... Specially if you're married. Because you've taken on somebody else's anyway in your surname. So in lots of ways, erm, I can be the person I should have been, the person I've always wanted to be, the person I regret I wasn't, as a mother. All sorts of things. It's a, it's a sort of second chance.

As a minister's wife, Jean has lost her sense of self in trying to meet the demands of others. She sees the role of the minister's wife as defined for her, with demands which she has to try to meet, and not as a role she can define according to her own abilities. This is an experience of loss which can be related to depression.

> Jean: Um, being what people expect me to be is the most difficult bit. They want, basically church people want a very friendly extrovert person, which I am not.
> Siân: Yes.
> Jean: So I've had to er, sort of, teach myself to be more friendly and - . It's very different, when you teach yourself to be something that you're not you lose sight of what you are. Are you this new thing that you've created or are you still basically the introverted, shy, retiring, lacking in confidence person that you've always been? I don't know.

Hilary suggested that her marriage was oppressive and that within it she has not been able to experience her own person. Like Jean, she has experienced her marriage as a loss of personhood.

> Hilary: I used to go... out walking, you know, on a Sunday, in the Highlands, you know? It was the north of X and I used to just go walking all the time. And go to aerobics and I used to go and visit friends and things. So I felt as though I was really free and I was my own person you know. And now I feel that I'm not myself, you know, I haven't been myself for all these years.

Although Hilary is aware of her loss she clings to a relationship which she elsewhere describes in negative terms. This contradiction remains unresolved, and renders her powerless.

5.2 Motherhood

The loss of self which some women experience in motherhood may be better understood as the loss of a potential self. In motherhood, women may feel that they have lost a potential freedom to achieve independence and autonomy. Some women may be aware of a loss of potential for a freedom which they may have never actually experienced but which, once lost, they believe other women have.

For example, Cate had no time for her own development because she was involved in full-time childcare: she gave up an Access course because she could not find time for herself. She was unable to take up opportunities to change and take control of her life, and her own needs were in opposition to the demands of her child.

Cate: I mean, I started an Access course at college doing Social Studies but I had to give it up 'cos Ben [son] just wouldn't, like, settle in the crèche, and when I was at home I couldn't get any work done because he was there all the time.

Fran has resolved some problems in her relationship with her partner and gained some sense of autonomy, by recognising the hopelessness of any reciprocal relationship with her partner and also by recognising that she is no longer liable to help him. She is empowered by recognising the limits of her responsibility for others and recognising her responsibility for herself.

Fran: And after I had Clive [younger child], erm, I just thought, "I'm not going to let this person bother me any more. I'm going to work, I'm going to forget about whatever's going on with him, I'm not interested. If he doesn't want to talk then that's his loss."
Siân: Was he living with you?
Fran: He's still there and he's still here now, but um, I'm not going to er, that is him I can't change him, I can't make him do anything. You haven't got the right really to make anybody do anything they don't want to do. All you can work on is yourself, whatever situation you're in, anything you can change your attitude towards that person, you can't make them change towards you. Do you know what I mean?

However, she feels tied to her partner, and while she claims that she is capable of leaving him she does not feel free to leave.

Fran: I could walk away tomorrow and I really, really, could do that now. It's took me three years to feel like that. That if I didn't have kids to him then

> I would have up and gone. You know, I find things, I do find things hard to walk away from -.

6. Summary

6.1 Acceptable women

Women's identities as wives and mothers may be powerfully constructed in their relationships with male partners, reflecting collective social judgements of the "good" wife or mother (Jack, 1991; see Chapter Three, Part II, section 5.2).

For example, Hilary sees herself as a failure because she has not lived up to the standards of motherhood defined by her partner. She accepts her partner's criticism that their child's problems are her fault as his mother. "Mother-blaming", a popular social practice (Dowling, 1981; Nicolson, 1993b), is seen here to be incorporated into her experience of herself as a mother through the reproduction of dominant social values in her relationship with her partner (Jack, 1992).

Women are not only defined by men in their relationships with them, but experience *themselves* in relation to others (Gilligan, 1982), in particular in terms of partnership or marriage, and motherhood. Marriage and motherhood are important features of female gender socialisation, evident in adolescent girls (Beckett, 1986; Griffin, 1986, 1988). For some women, self-respect may depend on being recognised as a "good" wife and mother (Brown and Harris, 1978).

This is seen, for example, in the interview with Beatrice, who had seen herself in traditional roles as a wife and mother. She had failed to fulfil her ideal, of marriage and motherhood. Her actual experience of motherhood was disappointing, and she feels trapped. She grieves over her lost potential for autonomy and independence, and has no alternative role in which to validate herself.

Women may not be able to fulfil their own needs outside relationships, when their constructions of adult female identity are based around notions of marriage and motherhood. For example, Fran said that she was unable to leave her partner because she had his children, although she saw herself as independent of him and no longer felt any satisfaction in the relationship. Marriage and motherhood go together (Gittins, 1985; Nicolson, 1993b), and the choice to leave a partnership may define a woman as failing to meet social criteria of acceptable womanhood.

Similarly, Jean chose to stay with her husband, and gave up her independent career in order to fulfil social expectations and support him in his profession. Being a cleric's

wife involves a double burden since she is married to her husband's job (Finch, 1983) and her choices are further constrained.

The definition of a woman's identity in terms of partnership and motherhood may therefore place constraints upon her which impede her development as autonomous and independent, and which devalue her achievements outside the roles of partner and mother. Some women may realise their loss of potential for freedom and autonomy once they have become mothers and neither meet the ideals laid upon them nor themselves find satisfaction in motherhood.

6.2 Dominant discourses

Women may not necessarily simply internalise dominant social or male values but may actively reflect upon them, and position themselves in relation to them (see Chapter Three, Part II, section 5.2).

While women may reflect upon and question traditional, dominant social values, it is difficult to fully reject these, as for Hilary and Jean, or, while rejecting them, to formulate an alternative discourse within which their achievements are valued in their own terms, as for Ros.

For example, Hilary appears to have accepted definitions of female success in terms of her roles as a wife and mother, and thus accepts her partner's definition of her as failing. Although she was also aware that she had other attributes, such as her intelligence and her past professional work, which were not recognised, and was angry about this, she was unable to value herself on the basis of these.

Jean recognised the impossibility of the ideal of the "superwoman" who manages to have a successful career and is also successful in traditional roles as a wife and mother. Although the demands upon her are impossible, she is unable to reject them as a standard against which she measures herself and she judges herself as failing against this ideal. Jean felt guilty because she was unable to fulfil roles in her own professional career and as a cleric's wife and as a mother. She is aware that "superwoman" is an ideal, but it is one she feels is expected of her and which affects her view of her own competence as a woman. She has decided to be a full-time wife, because that is what is expected of her.

Ros has not simply internalised dominant social and male values about her role as a wife and mother, but has reflected upon them and rejected them. Yet she has a problem in formulating alternative values and roles within which she can validate and express

herself. While she may be able to question the dominant discourse and reject it herself, she is aware that others judge her against it, for example her family of origin, and it is difficult to formulate an alternative discourse. Part of her struggle has been to develop new activities and a place in society where she can validate what and who she is. By contrast, Jean has lost her sense of self because she has attempted to fit traditional expectations of her as a cleric's wife and to change herself to meet them.

6.3. Personal and structural issues.

Women themselves may be conscious of social, structural constraints or they may reconstruct them at a purely personal level (Currie, 1988; and see Chapter Three, Part II, section 5.2). This has implications for how they experience motherhood.

For example, Ros was aware that her own family saw her, as a woman, merely in terms of fertility, and she explained some of her problems in motherhood as social issues, in terms of the social construction of gender roles. However, Penny experienced the conflict between her roles as a mother and breadwinner at a purely personal level. She felt guilty because she was unable to both go out to work and be a full-time mother, but she explains her guilt as natural to women, and understands this as a personal and not a social issue, since to be female is to feel guilty.

The interpretation of problems at a personal level may thus leave a woman feeling that she is inadequate. However, even where women are aware of the social issues involved, this does not necessarily empower them to effect change in their lives and may leave them feeling frustrated and angry. For example Ros, in struggling to define new roles and a non-traditional identity for herself as a mother, encountered the traditional attitudes of her own family and was clearly angry about these, and still limited by social structural constraints in the changes she made in her life.

Women may encounter social and structural difficulties in acting in alternative ways, and in challenging rather than reproducing traditional social structures within the terms of their own experiences. For example, Ros struggled to find alternative roles in society as a woman and a mother. Jean, as will be seen in Part B, experienced herself differently in her role as a volunteer to her role as a minister's wife, since as a volunteer she was able to leave behind the social constraints which she experienced in her role as a minister's wife. Women are structurally constrained by, at the same time as they incorporate and act to change, dominant values and structures, in a recursive process, as in Gidden's theory of structuration where the individual is seen as both reproducing and acting upon social structures (Giddens, 1979; see Chapter Three, Part II, section 6).

It may be important for individual women effecting change in their lives to recognise the commonality of the difficulties mothers face as a group, and to recognise the importance of social issues, although their own experiences are individualised. This recognition of experiences as shared may challenge feelings of personal inadequacy and responsibility and may be experienced as empowering. [1]

[1] It is worth noting here that in Study I (Chapter Two, Part II, Part D, section 3), Janet recognised the importance of defining responsibility on a broader social and cultural basis in a feminist approach. Personal issues can be reinterpreted as social and cultural issues, for which the individual is not fully responsible.

PART B : WOMEN'S EXPERIENCES OF MOTHERHOOD

1. The social construction of motherhood: ideology, expectations and disappointment

Many women interviewed were disappointed in their expectations of emotional fulfilment through motherhood. Margaret, a full-time worker for the voluntary organisation, believed that many mothers had expected that having a child would meet needs for intimate relationship, which had not been met in childhood nor through their partners, and also their needs for status and a sense of importance in society.

> Marg: That's the sad part about it. As I was saying, for, er, for young mums, especially the ones that have been in care. Er, and they want somebody to love them and they'll often go and have children because they think it'll give them status and everything, and somebody will be there just for them.

Ros identified the ideology surrounding motherhood as a problem, since this ideology was contradicted by the actual experience of motherhood. Ros had felt cheated, since her high expectations could not be fulfilled, leading to shock and disappointment.

> Ros: And the whole sort of ideas are there, certainly for the first child - not having had much contact - not having had much contact, and it's quite a shock, you know, a horrible shock to find you've been bombarded with all this wonderful 'Mothercare' image - and it was so much more difficult and exhausting because I hadn't had any kind of contact with children and parenting. Um, so that um, when it was so unglossy -.
> Siân: Was it, in a sense, a big disappointment?
> Ros: Um.
> Siân: Or how does it make you, kind of, feel about it all?
> Ros: Just conned really. Um, but um, yeah. Yes, conned that it was going on and people perpetuating it. Um, and I certainly feel that, I mean, I've had quite a difficult low period recently.

Fran considered that the social construction of motherhood as fulfilling was misleading, and that motherhood was not wonderful nor life-transforming.

> Fran: And it [motherhood] isn't what it's made out to be in that way. Having kids doesn't suddenly make everything in your life brilliant it's just, you know, they're just born and your life continues the same, you know, the same way.

2. Contradictory experiences in motherhood

Beatrice, a single parent, found some pleasure in motherhood.

> Bea'ce: I do, but, Darren's a bit clingy. He wants me all t' time. Joanne's not too bad now she's started nursery. It's good when they learn things, like when they take first steps and first words.

But she also said that she regretted her decision to have children and that motherhood was in itself depressing.

Siân: Yes, if you were to have the choice of things that you would change, that would help?
Bea'ce: I don't think I'd have got pregnant. It's horrible to say, but-.

Overall, she has found motherhood depressing.

Siân: So would you call it depressed?
Bea'ce: I'd call it...
Siân: What?
Bea'ce: Motherhood.
Siân: Yea, yea. It's just depressing having children?
Bea'ce: Pardon.
Siân: Is it just depressing having children?
Bea'ce: Yes.

Penny said that at times she felt very low and depressed, even suicidal, particularly after the death of her own mother, but she also found purpose in her relationship with her two children. Paradoxically, motherhood is the cause of many problems and also the reason she struggles on.

Penny: So I had that [her own mother's terminal illness and death] on top of just having had a baby and, you know, really down. It was only like these what kept me going. I used to feel like taking summat, you know? Ending everything and wanting to be with her [her own mother] like, but you can't. Life goes on and she wouldn't have wanted that anyway. She would have wanted me to look after these, so -
Siân: So, in a sense, is it really like the children that keep things going?
Penny: In a way yes. 'Cos sometimes I feel I could just - you know what I mean?
Siân: Yes.
Penny: And be done. But I know what I feel like without a mum and then I think well, what would they feel like if I did summat like that you know? It's not fair on them, so - um -

Penny can be seen to find purpose and meaning in her relationship with her children. The real problem for her is not being a mother in itself, but the incessant work involved and the loss of time for herself. She finds meaning in motherhood at a reflective level, and being a mother enhances her sense of her own identity. Her difficulties and doubts about motherhood focus on the daily routine of endless childcare.

Penny: If anybody, I mean, it's awful to say it like, but I suppose if anybody had told me what it was going to be like I think I'd think twice about having any. I think like, you know what I mean, I'd have thought twice about having any. I wouldn't be without 'em, well, I would if somebody could take 'em away for a few hours and fetch 'em back - I wouldn't be without them permanent if you get my meaning. But just to be on us own for a bit would be nice.

She experiences conflicts between these two aspects of her experience of motherhood. While she finds purpose in her responsibility for her children, it is a real problem that she is always responsible for them and has no time for herself.

Penny: It's funny that, when you first, you know, like when you first, like when I first had Joe, and Julie, you've got another person to worry about and to think about, and you know? (Comments to children.) But it gets on your nerves, when you have got company, when somebody does come at night and these are - you can't have your conversation for - you know what I mean?

3. An inadequate mother: blaming oneself

Jean was a volunteer whose adult daughter had committed suicide only eighteen months prior to the interview. (I had not been aware of this until she told me during the interview). She suggested that she regretted her actual experiences of motherhood, and that she felt she was inadequate as a mother and did not fulfil herself in her role as a mother.

Jean: So it's, it's a challenge [her volunteer work]. It's me trying to be useful. It's me trying to make up for the fact that perhaps a third of my raison d'être has disappeared into thin air.
Siân: Yes.
Jean: And I want to make good - that in some way I want to help people who are living under stress if I can. Er, it's tied up with all sorts of things and certainly I often feel that I've, I must have gained more from my visits than the family have. Erm, so it's definitely two way, a two way thing.
Siân: Yes. You said something earlier that they see you as you rather than a -?
Jean: Yes. Er, I am a Minister's wife so I am an appendage.
Siân: Yes.
Jean: In lots of my activities I'm standing in for him or I am assisting him or I am tailing along behind him.
Siân: Yes, that's awful.
Jean: I am not myself. Erm, I was a professional person as a school teacher. I'm not that any more, though this is something for me, for [volunteer organisation], which has nothing to do with the rest of my life. Therefore, perhaps, I present a different person when I'm doing that.
Siân: Yes. Is it, um, I don't want to put words in your mouth, is it, kind of, freer in a way?
Jean: Mmmmm. Yes it is. Because nothing of what I am in that reflects onto the other people that I am. I don't talk about it because it's a, the work is um, done in confidence anyway, so it um, I mean, obviously, there is an overlap but in another sense there isn't an overlap. So, and I don't carry a surname with me.
Siân: Oh no they don't, yes.
Jean: So my only identity is my Christian name. And your Christian name really is your person isn't it?
Siân: Yes.
Jean: 'Specially if you're married. Because you've taken on somebody else's anyway in your surname. So in lots of ways erm, I can be the person I should have been, the person I've always wanted to be, the person I

> regret I wasn't, as a mother. All sorts of things. It's a, it's a sort of second chance.

Her work as a volunteer visitor is an opportunity to re-experience motherhood in a more meaningful way, as a person on her own terms, because she is not constrained by other aspects of her life and identity, and in particular by her married identity, by the constraints of her marriage and her public role as a cleric's wife. In her voluntary work, she is free to be herself. Her identity and role as a mother are important to her, and she has an opportunity in her volunteer work with young families to feel herself useful again and to enjoy young children. While this may be read as a way of coping with her daughter's death, it can also be read, in the light of the interview as a whole, as her recognising her own needs as a mother.

Penny experienced her problems in motherhood as individualised. This again is related to her experience of motherhood on an individualised basis, where the problems she faced were not acknowledged as common problems and she was left feeling that she herself might be the problem. She believes that the problem may be that she is an inadequate mother, not that motherhood is difficult.

> Penny: Yeah. You think you're only one, you think you're only one that's having problems, you know? You feel on your own.

> Penny: It [having children] just completely changes your life it does. I don't know, it might be different for some mothers. Some mothers might take to it right well, I don't know if it's just me or, you know-.

Cate says she is seen as having everything she should want as a woman. Her socialisation as a woman means that it is difficult to acknowledge that she has a right to feel depressed, and she feels that there is no recognition of the problems she faces.

> Cate: That's what people say isn't it? "What have you got to be depressed about? You're married. You've got a lovely husband and a kid and a nice house", you know.

Cate felt she had no real reason to be upset, and she found it difficult to discuss how she was feeling. She felt that she had no real problems, that she was inadequate. She believed her problems were individual not common, nor a valid experience of motherhood or depression (her G.P. had told her that she was not suffering from depression). She implied that she felt inadequate in having problems and in not coping with them better. When I asked her what she would do if she felt down, she said:

Cate: So, yes, I'd probably go and see Sue [supportive friend]. I wouldn't really, I wouldn't go to the doctor again. Um, and I wouldn't, I wouldn't go to, like, a support group or anything. I mean, I used to go to the support group for single parents and er, that's where I met Sue. Um, but, you know, I wouldn't, sort of, sit there and discuss how I was feeling and my problems and everything. I couldn't do that.
Siân: Why?
Cate: I don't know. Because I find, I suppose because I get embarrassed because I think I'm getting upset about nothing. And it's like, everybody will think I'm really pathetic for getting upset, you know?

4. Loss in relationships: grief, adaptation and change

Interviews with participants suggested that previous relationships may be reinterpreted and questioned through the experience of motherhood. Fran reflected upon her experiences as a child, and her relationships with her parents. In particular, her past and present relationship with her own mother became problematic.

Fran: I think it's er, it just forces issues, brings things up, and I think especially relationships with parents or your mother or you know. It's brought up a lot of erm, me and my Mum really are not - it's just made me question so much, you know?
Siân: Yes.
Fran: And she feels really attacked a lot of the time. I'm more accepting. I was really, like, critical of her, erm, you know, and it's brought up a lot of things. Especially when I'm dealing with my kids and I think how she, you know, how she was with me. It makes you think, "Well, I wonder if I'm like this, how was she?" You know? And it just brings up so many different things I think and it affects a lot of areas of your life.

The emotions she experienced, as a mother herself, led her to reflect upon her past experiences and her own experience of being mothered.

Fran: All the things what really were there all my life, right from my childhood what I'd built up that had never been acknowledged. And then I had my first baby and because that's quite an emotional experience and you get a new perspective on it, it just makes you look, it's made me look at a lot at things to do with my Mum - and me and my Mum were just at loggerheads for erm, er, even now things aren't properly right with my Mum really.

Beatrice tried to mother differently from her own mother. She experienced a retrospective sense of loss, questioned why she had not had what her children now had, and believed that she loved her children more than her own mother had loved her. (She had also spent most of her childhood in institutional care and foster homes).

Bea'ce: I don't know. I think it has. Me Mum did a bad job of bringing us up and I just want to do it better and give 'em more love than what she did.

Interviews suggested that becoming a mother may lead to changes in present relationships and re-evaluations of past relationships, and that these changes may be sources of grief. For example, Ros's relationships with her parents changed during her pregnancy. As a mother herself, she was more aware of and reflected upon her own experience of having been mothered, especially by her grandmother. She felt an acute sense of loss, at a time of and possibly as part of the process of personal transition. Demands on her were high, and a further problem was that she had inadequate support to deal with the conflicts she was faced with, because she felt friends were not interested. Her reassessment of herself and of her past experiences led to changes and feelings of loss in both past and present relationships.

> Ros: Yes. I mean, I certainly think I had a lot to grieve over. I mean, it tremendously changed my relationship with my parents and I realised all during the time I was pregnant, half way through... it wasn't going to work out, and I'm still working through that now, but that was a lot to grieve over. Um, and it brought up a lot, you know, of previous relationships, you know, mothering relationships that I'd had with my grandmother, that I felt mothered by her. Just the fact that there was a lot to grieve over, I found that quite lots of friendships because they didn't understand what I was going through or - you know, when I wanted to talk about, I had a terrible childbirth experience that they just didn't want to hear. And that was - I think that really, I mean, I still feel sort of pained by that now five years on.

5. Summary

In a contradictory construction, motherhood is both self-sacrifice and fulfilment. Women are unable to acknowledge problems, let alone attempt to meet their own needs within social constructions of motherhood, since they should be natural mothers, who both have no needs and whose needs are met through their children.

Women can be seen to measure themselves against the "other" of idealised motherhood or womanhood, the romanticised ideal of motherhood (Ussher, 1990; Nicolson, 1993b), and to experience themselves as defective against this. Far from seeing themselves as skilful in coping with motherhood, women may see problems in terms of their own inadequacies (Boulton, 1983). While women may be idealised as mothers in the abstract, in practice they are not valued as mothers nor are their skills recognised. For example, Cate was aware that she was doing a worthwhile job as a mother but this belief was difficult to maintain because her skills were not recognised.

The construction of motherhood as fulfilling is in terms of a reciprocally fulfilling mother and child, as if they are a self-contained unit, as in psychoanalytic versions of motherhood (Balint, 1949, 1965). In the romanticised version of motherhood (Ussher, 1990; Nicolson, 1993b), women have no needs which are not completely fulfilled

through motherhood. For example, Penny saw herself as defective because she wanted time away from her children.

This leaves women with a problem in making sense of what they do actually experience as mothers. Boulton (1983) identified two levels of experience: women found the daily routine of motherhood problematic and frustrating, but at a reflective level found purpose and satisfaction in their lives as mothers. These two levels are contradictory and can lead to difficulties as women try to make sense of their complex experiences as mothers.

Women may feel inadequate as mothers at the same time as motherhood is a meaningful experience at a reflective level. For example, Penny found that her children were the cause of many problems but also that they gave her a sense of purpose and gave her life meaning. Jean believed both that she herself was inadequate and that motherhood was a potentially meaningful experience which she felt she had been denied. Her daughter had committed suicide and she can be interpreted as reflecting upon her adequacy as a mother for her daughter, and on the meaning and importance of motherhood for herself. At least part of the problem was that she felt constrained in how she should mother, by her ideal of a good wife and mother. Her work as a volunteer befriender of young families gave her an opportunity to be with children on her own terms, and to re-experience herself in a mother role.

The recognition of the commonality of the problems of motherhood does not empower women to improve their situations. For example, Ros is aware of the ideal of motherhood as a happy and fulfilling experience, (Ussher, 1990; Nicolson, 1993). She feels angry but this does not empower her to change her situation. She is trapped within the social and structural constraints on motherhood, and has struggled to reconstruct new roles for herself as a mother.

But recognising the commonality of their problems may enable women to feel better about themselves, since the problem is then recognised to be a shared problem and a social issue and not simply a personal problem. They are not themselves defective. Fran was aware that motherhood was not the ideal it was constructed as. She also felt angry and resentful. She was not empowered to change her experience. However, the fact that it is a common experience makes *her* feel better. By contrast, Penny was not aware of how other women coped and so worried that she might be a poor mother. Cate believed that she was inadequate, that her problems were not in themselves "real problems", that she was inadequate in dealing with them and that they were imaginary, and she could not discuss them with other people.

The lunch time support group at which some women were interviewed was set up to encourage women to share their experiences and provide mutual support. As the group was only starting at the time I was interviewing it was difficult to see how helpful it was, but several women interviewed said that it gave them something to look forward to and a focus to their week. However, at another group I visited when initially setting up the study, which was also run by the voluntary organisation, women did speak of the support they provided for each other as critical in coping with their lives.

PART C: THE CONSTRUCTION OF "DEPRESSION"

1. The identification of "depression" as the problem

Women may not see their experiences as depression. Margaret considered that most women do not identify themselves as depressed. She only recognised herself as depressed through reflecting on her past experience, and thus recognising her present experience as depression. This gave her a sense of relief since it established that there was a definite and identifiable problem.

Siân: Would you say that most mothers do, at some time, suffer from depression? Or is it all part of the process?

Marg: I wouldn't - from what I've seen over the years I would say yes... The one thing I would also say with that is that they don't always know they're depressed. I mean I didn't at first. I mean, it was only really um, when I got to grips with myself after my third one had been born, um, and when she was about three years old I suddenly thought, "I've been here before". And it suddenly struck me that um, the lethargy I was feeling and the lack of action um, and the way, um, it took me so long to actually do something that should have taken me half as long, that I was depressed. That was actually great. You need labels. I don't care what anybody says, um, and I know the thing nowadays is to not label anything, but I actually think that's wrong. And having been in contact with people from all sorts of society, with all various ailments and illnesses um, and chronic sicknesses, you need a label to put on things, and depression is a label.

Siân: Is it... like there's nothing wrong with the label it's the meaning?

Marg: Yes that's right. It's then what you do with that. Um, yes. I mean, it's like the thing with the spastics, trying to change the name, I think they're right there because that's become a, it's now something derogatory and it shouldn't be at all. Er, it's not fair but it means - when you've got a label you can deal with things - it's the not knowing that is the problem.

Margaret considers that the label depression is valuable as a means of validation and legitimation. Thus, receiving a diagnosis of depression may define the problem and in this way be empowering. The meaning of the term "depression" may be problematic, however, because depression may be interpreted as a personal deficiency.

The recognition of a problem of depression can be seen as part of the process of making sense of experiences. The labelling of experiences as depression is a means of validating them, through identifying them as a distinct and limited problem. Making sense of experiences as a problem of depression may be liberating since it limits the problem to a contained and recognised problem, and through identifying the problem in objective terms the individual may be enabled to deal with it.

Fran: So I think, um, that I can look back on my life now and see times when I was actually depressed but never acknowledged it.

Siân: Mmmmm.

Fran: You know, I didn't have any enthusiasm. I used to sleep ever such a lot, which I think's a sign of depression - sleeping a lot - no motivation to do anything. And not doing much with your life and er, and then it was really when I had Callum my first one, three years ago, when everything just hit me... like, all my relationships just went... because that's quite an emotional experience and you get a new perspective on it.

Fran, in identifying problems as depression, draws on socially constructed versions of depression, as an illness identified through symptoms in a medical framework. As suggested by Margaret in the excerpt above, the meaning of the term "depression" can itself be problematic.

Identifying experiences as depression is a reflexive process, where the self is constructed or reconstructed as depressed. It demonstrates how the past self is constructed as the object of thought, as in Mead's (1934) concept of the "me" (see Chapter Three, Part II, section 3). The naming of past experiences enables them to become an object of thought to the individual, an object which is distinguished from on-going experience. In the reflexive process, knowledge is drawn upon, for example about the symptoms of depression as in the excerpt from Fran above, and patterns in experiences are identified, as in the excerpt from Margaret above, in making sense of those experiences. The self is seen to be reconstructed through reflection on past experiences from the standpoint of the present. There is a dynamic process of reconstruction of self drawing on both present and past experiences. As in Anthony Giddens' (1979) concept of durée, the meaning of experiences can be seen to be the product of a woman's particular social position and point in her life (see this chapter, Part I, theoretical issues in the analysis).

The meaning of the term "depression" is seen to be socially constructed, and individuals may also reconstruct the meaning of the term "depression" in a reflexive process, as they draw upon it in making sense of their own experiences. This is demonstrated in the ways in which individual women, for example Fran and Margaret, drew upon the notion of depression in reflecting upon their subjective experiences, in how they interpreted the meaning of "depression", in their acceptance or rejection of "depression" as a description of their experiences, and in their reconstruction of the meaning of "depression" as they reflected upon their experiences.

2. Reflexivity and the construction of "depression"

2.1 Knowledge of depression

2.1.1 Conscious and unconscious knowledge

Women may deliberately avoid identifying their experiences as depression. This suggests a distinction between tacit, unconscious knowledge and discursively constructed or conscious knowledge. Thus women may internalise blame for the difficulties they experience in motherhood, experience low mood and yet not describe themselves as depressed.

The validation of their problems as depression may be an escape women feel that they do not deserve, since they are unable to validate their problems. Depression may also be an escape women feel they cannot afford if they are to continue to meet the needs of their children. They may avoid identifying their experiences as depression in order to avoid pathologisation.

> Cate: Things like, I go from one thing to another and I'm married now. My husband's schizophrenic, so that gets me down.
> Siân: That must be really dreadful.
> Cate: Difficult, you know, because I've got Ben [toddler son]. He's at a really difficult age and really demanding and then I get worried about Jim[husband], a bit down about that. I won't say it's depression. I don't know, you can't let yourself. I don't know, I suppose you're like sub-consciously trying not to let things get you down because if I go down then there's nobody for them. So you have to try and push it out of your mind.

Cate blames herself for her problems, sees herself as inadequate and at the same time does not allow herself to think of herself as depressed. There is a suggestion here that the definition of her problems as depression is an escape which she does not deserve. Denying that she is depressed may also be defensive, since acknowledging her problems as real may mean that she also acknowledges that she is unable to cope and is inadequate in some way.

Cate's avoidance of the term depression can be understood as an avoidance of pathologisation. If she identified herself as depressed, Cate would be acknowledging that she was inadequate in coping with her life. In validating her experiences as depression, she would be suggesting that she was allowing things to get her down and placing the problem in herself as an individual.

2.1.2. The meaning of "depression": avoidance of and alternatives to "depression".
Women may avoid the term "depression" as pathologising. Depression may be constructed as a problem of "other" which is not applicable to one's own experiences. This is achieved through constructing "real" depression as a severe problem which cannot be related to one's own experiences, and is seen in others but not oneself.

An alternative explanation of a woman's problems to that of depression, may be constructed in terms of her social circumstances and life experiences (see the excerpt from the interview with Cate, below). In addition, the identification of oneself as "really" depressed may be avoided through the construction of oneself as having been depressed in the past but as no longer depressed, and the original experience of depression may be constructed not as pathology but as a reaction to particular circumstances.

However, the rejection of the notion of depression left women interviewed with a problem in validating difficult experiences. The alternative to the discourse of "real" depression appears to be the notion that the woman herself is weak and inadequate in coping with her problems. Cate, for example, suggests that others would construct her as morally inadequate, for example as selfish in "indulging" herself in depression. If the problem is not a "real" problem of depression, then how can she account for her difficulties?

Excerpts given here are used to demonstrate how accounts of experiences are structured so that the term "depression" is rendered inapplicable to a woman's situation. This is demonstrated in excerpts from interviews with Cate and Penny. Both women rejected the idea that they were currently depressed, and explained their difficulties as caused by their circumstances. At the same time, they were anxious to avoid the notion that they were personally inadequate in not having dealt better with their circumstances. Penny achieves this through suggesting that she is aware her situation could be worse, so that she is not seen as complaining, and also in recognising the real difficulties which she faces. Cate rejects the notion that she is weak, but is left without an alternative discourse in which to construct her difficulties. Throughout there is an implied notion that they should be able to cope. They are positioned between alternative notions of depression as pathology and as personal weakness or self-indulgence; which imply that depression is not something which can be justified by their circumstances.

Cate acknowledges that there are factors in her life which lead her to feel low: her marriage, her recent move of home, giving up drugs, her attempts as a single mother to cope with her son. However, she avoids the use of the term "depression", which she

understands as meaning clinical depression i.e. a medical state. She explains her problems in terms of her social situation and past circumstances. Yet she consulted her G.P. because she no longer felt able to cope on her own, although she did not see herself as clinically depressed.

Cate: Have I ever been depressed? Well, I've been, well yea, not right down, I suppose, like clinical depression or anything, no. You read about, you know, people who have to like go into hospital, you know. I haven't had it like that, just suddenly things get on top of you and it don't seem like there's any way out of it and it's just like a downward spiral, you know. I mean, I went to the doctor about it because, like, you know, I was a single parent. I'd just got married, I was trying to cope with Ben [toddler son] and he was a real handful. I used to have a drug problem like before I had Ben... and I'd just moved up to [city] as well, so I was like really isolated.

Cate believes that in "real" depression one is irrational and out of control. (In Study I, depression was described as being out of control of oneself. See Chapter Two, Part II, Part C, section 5.) She, on the other hand, knows what she is doing. So she constructs herself as not suffering from real depression, as a medical condition, and also rejects the alternative notion that she is selfish or self-indulgent. But she has no alternative discourse available to explain her problems.

Cate: Yes. You know, I can't - I think depression, I don't think you would realise what you were doing if you were depressed, would you? If you were - . I think, like, I'm aware of what I'm kind of doing and things like that but I just, I want it you know, and it doesn't seem important what anybody else wants. It's just me and I need that. I seem to feel depressed and it would be like, kind of, not knowing - you know, being aware of -
Siân: Yes.
Cate: I don't know, I think I can... you know, being like dumb and that, it's, like, really selfish.
Siân: Do you think it is selfish?
Cate: No I don't. But I think, you know, that it is, that's what I was brought up with, that kind of idea. You know, I think, like, you get confused about that sometimes. Where you do, like, breakdown and make yourself, and you, sort of, think you shouldn't be doing this, this is wrong.

She explains her depression as an issue of personal control and personal responsibility. In contrast to the loss of control in "real" depression, she is in control of her mind and her emotions. But implicit in this is the idea that depression, if chosen, is then a form of self-indulgence.

Cate: It's, sort of, like, er, I don't know, it's like, you know, it's my mind, you know, I'm the one that's controlling it. If I'm getting down it must be, like, my problem. If somebody said something bad to me or Ben's done something that's, it's my decision to get angry about it and work myself up. So, I suppose it's like, it comes back to, you know, you've got the

ultimate control over yourself so... you should, like, pick yourself up and get on with it.

Penny says that she has felt depressed and explains this through a specific cause, the death of her mother, combined with the birth of her second child. The implication is that she is no longer depressed, that her experience of depression is in the past only and that it is explicable in terms of a specific set of circumstances.

Penny: I don't know. I wish you'd have come, you know when it were first happening and everything and then it would have all been fresh in my mind then, you know?
Siân: Is it the sort of thing you actually forget quite quickly or - ?
Penny: I have now because it, well at time it were when my Mum died you know? And I'd just had Julie, she were, you know, four months, only just four month old, so everything were rolling into one you know. I felt isolated and no help from anybody, you know? I just felt all on my own and that. Just wanted to go and hide away really.

However, later in the interview she suggests that she still feels low, or depressed, though less so. While she avoids describing herself as depressed, it is evident that she is experiencing difficulties, that these are related to her circumstances, and that she has little hope of improvement.

Penny: Anyway, like I say when my mum died, I was crying a lot more and everything - but like things have got easier in that sense. I'm not as - that's what I said, if you'd have come at that time, round about that time it would have been different, but like it's got easier and better - in a way my life, but yet it's still hard because of these two, money situation and things like that. I mean, I suppose there's thousands out there that's same and that.
Siân: Does that make it any better?
Penny: Well not really but, you know, I try and think to myself I'm not only one, you know?
Siân: Yeah.
Penny: Really. And like people in other countries, poor countries what you see on television, even worse off than you aren't they?

It is clear that she is distressed by her situation, but she attempts to minimise this distress by comparing herself to others worse off. This may be a way of coping with her personal difficulties, by recognising that they are shared problems and not unique to her. Through this comparison of her situation with others, she suggests that she is coping at least as well as everybody else in similar situations and further distances herself from the notion of depression as personal inadequacy.

2.2 The reflexive reconstruction of depression in terms of subjective experiences.

In contrast to the rejection of the notion of depression as pathology, as illustrated by the excerpt from Cate above, some women interviewed reconstructed the notion of depression, drawing upon their subjective experiences in giving it meaning.

Depression is reconstructed as a meaningful personal experience of self, as a dynamic experience, as a process rather than a state. It is understood as a process of personal change offering opportunities for personal growth and development.

Anthony Giddens' (1979) concept of durée is demonstrated here, in excerpts from interviews with Ros and Fran, as they make sense of their present and past experiences from a particular point in their biographies. For example Ros, below, describes her experiences in terms of a process of personal change, and from the standpoint of her present position as a parent trying to parent in a different way from her own parents.

Siân: Yes. Um, so you, would you say you still get depressed now or - ?
Ros: Um, well I have a little difficulty with the word depression.
Siân: Oh yes, what do you think it means or - ?
Ros: Yeah, um, well, sort of, I think yeah I do get depressed, but I think it's kind of like a layer in my experience because I can feel happiness at times but I've got this, like, layer of undealt with stuff... Um, and... I suppose I could say I feel quite happy and depressed at the same time. And it depends on how it's working out and where it comes through... Er, and just, the change of it, you know, and I do feel, because I'm really trying to live differently, um, um, I'm trying to break away from my parents and be a different kind of a parent, and really trying to change particular aspects of um, just, I suppose I didn't realise how difficult it is. (Comments from child.) Um, yes I do and I don't feel it's a problem. It means I feel low sometimes and um, I don't think it's wrong to ask for help. I mean, it's one of those things I think I perhaps learn -.

Ros was initially ambivalent in identifying her experiences as depression. She implies that the term depression, as commonly understood, is inappropriate and reconstructs the meaning of depression in terms of her personal experiences. She understands depression as a dynamic and variable experience, rather than a static state, as on-going and part of more complex experiences of a variable self. For example, she can feel happy and depressed at the same time.

Depression has meaning for her as a process of personal change and development. She suggests that the causes of depression are located in her past experiences but that she experiences it in the present in particular situations and circumstances.

Depression may be retrospectively explained as a potentially constructive experience, and an opportunity for change and self-learning, as by Ros above and Fran below. But

this may be easier when the person no longer feels depressed. It may only be because she no longer feels depressed, is no longer stuck in depression, and has changed through her experiences of depression that Fran is able to identify depression as a dynamic and constructive process:

Fran: The only way I can talk about things really is from having come through a lot of things.
Siân: Yes.
Fran: That I feel I can understand things more, and I think it's like, um, it sounds a bit corny but I think it is like, if people have gone through things, if you come out the other end, if you do feel positive about things eventually it really is more like a gift than -
Siân: Ahhh it doesn't sound corny -
Fran: It can be, you know, because you can learn so much more about yourself after you've gone really in -
Siân: Yes
Fran: - and then found the strength to come out the other end, you know?

2.3. "There's something wrong with me": accepting the notion of depression as a medical problem.

Some participants understood depression as an illness, as something which happened *to* them. Here, the woman was constructed as pathological through a medical discourse, and as irresponsible and incapable of controlling herself. Women, who accepted the medical diagnosis of depression, explained depression as a medical problem and defined themselves in terms of that problem. Pathologisation may potentially free a woman from criticism for her behaviour, within a moral discourse, but accounts suggest that this is not necessarily so.

2.3.1. The uncontrollable self.

Jean was an obviously intelligent and competent woman, who had been taking lithium for fifteen years and understood that she was a possible manic depressive. She constructs herself as irrational and uncontrollable despite her attempts to plan her life, and suggests that control needs to be imposed on her from outside. She experiences feelings of guilt and increasing stress and self-recrimination. She still sees herself as responsible for her behaviour although she understands manic depression as pathology.

Jean: Er, well they're all [mood swings] linked up because, you see, when I'm on a high I would set, I think I can cope with everything. You know, I'll be prime minister as well! So I plan it all. And then something unforeseen, like, um, and very often it can be emotional. Erm, I fall out with somebody or I get um, too excited and say more than afterwards I think I should have done, and then I have dreadful recriminations and I've got no-one to talk this through with so it then plays on my mind and I don't sleep and I'm tired, er, and it's all, you know, this knock on effect. And um, I get in a bad state and, and to a point where I could actually be, go under I think - collapse, flip, whatever you call it. Er, now if I could

be restricted to making the week's plan, a month's plan, a yearly plan which is cope-able with whether I'm under stress or not, if I could be kept within those confines it would probably be a good idea.

2.3.2 Popular understandings of mental illness, and stigmatisation

Jean constructs herself as out of control and irrational, as dependent on lithium to keep her abnormal mood swings under control. She suggests that her "norm" is defined through the administration of drugs, and is controlled through drugs. She explains that she does not tell people that she is a manic depressive because they would think her abnormal:

Jean: So if I talked to them [neighbours and friends] and they realised that they were living with somebody who is abnormal -
Siân: Well, do you think you're abnormal?
Jean: Well, apparently, no I'm not supposed to be. Erm, providing I'm taking lithium. So I suppose I'm as normal as somebody who takes painkillers for their arthritis to keep them in sweet temper.
Siân: Yes. Yes. Or - .
Jean: But I wouldn't be looked at the same as somebody who's given painkillers for arthritis would I?
Siân: No.
Jean: That's the problem.

The popular construction of mental illness as pathology and stigmatising is a powerful discourse, which Jean is unable to reject. While at one level Jean is able to reject the notion that she is abnormal, at another she has incorporated it into her construction of herself. Having recognised that she would be seen as abnormal by others, she does not tell people that she takes lithium. While she explicitly rejects the idea that she is abnormal, she indicates throughout the interview that she does see herself as pathological and deficient. This is compatible with Giddens' (1979) structure of knowledge (see Chapter Three, Part II, section 4.3), and illustrates how discursively constructed and conscious knowledge may be contradicted by practical or tacit knowledge implied in individuals' actions.

Jean defines herself as a problem, for example for her husband, suggesting that this is how people would see her if they knew she was a manic depressive, and that this is how she sees herself.

Jean: But I never tell anybody that I am a mild manic depressive. Um, I excuse myself by saying that they wouldn't know what I was talking about anyway.
Siân: Well isn't that - ? Yes.
Jean: But that isn't the reason I do it. It's because it's got, it's connected with mental health... And I don't want them people, them people! those people to be, um, sorry for my husband because he's got to deal with a half demented wife.

Siân: Yes.
Jean: Aahhh. Poor thing. You know, I don't want that. I want them to see him and me, although they don't perhaps, but I still want them to see him and me as ordinary people.

2.3.3 The pathological self.

Ann explains depression as a problem which is contained within her, and defines herself as depressed.

Her behaviour is explained by others through the notion of depression. She is defined by the medical authorities as pathological and irresponsible.

Ann: They said I'd been acting stupid in t'day, been right sullen and that. They said I were doing it to cover up for me depression and they said I weren't being responsible.

She understands depression as an objective problem, which is distinct from her person. Depression is the cause of her difficulties, it is something contained in her mind which takes her over:

Ann: Yea, yea. I've had sort of depression for a long time, but since I started coming to this group it's made me think that I've got somewhere to go. I don't always have to dwell on the depression all the time. I find myself just dwelling on it all the time. Depression: I can't get it out of my mind.

However, depression is also a distinct problem, which she wishes to escape from and which she distinguishes from herself:

Siân: Could you say how depression feels? What it feels like?
Ann: It's just dreadful because whatever you do you just can't get away from it. You lose a right lot of energy, no energy to do anything at all. You just feel so lazy.

But although she can identify depression as a distinct problem, it also defines her as depressed and becomes a dominant aspect of her personality and identity:

Ann: I've known about that since I've been right small, depression, and I've said to meself, "I'm depressed, I'm depressed". I've known, I've always known what it's been like to be depressed.

3. Explanatory frameworks: explaining depression in terms of circumstances or biology.

Individuals may or may not identify their experiences as depression. They may use the term "depression" in different ways and with variable meanings. Analysis of the use of the term "depression" has demonstrated ways in which women interviewed attempted to make sense of their experiences within their accounts.

One question is, how did women interviewed explain problems which they experienced in their everyday lives? Women interviewed accounted for their problematic experiences using two explanatory frameworks. They explained their problems with reference to their situation or with reference to self. These explanatory frameworks were also identified in the analysis of data from psychiatric out-patients interviewed in Study II (see Chapter Two, Part II, Part C), supporting Karp's (1994) analysis of patients' subjective accounts of depression.

While situations may be recognised as difficult, women may still be constructed as inadequate if they are unable to cope with these situations. Coping was important in maintaining their identities as good wives and mothers (see Part A, above).

A medical discourse of depression as pathology was seen as inappropriate and avoided or rejected by some women interviewed, as has been demonstrated. But the medical discourse, as has also been demonstrated, was also powerful in validating problems and offering potential explanations in terms of the individual's biology. It was used by some women interviewed to explain their problems in terms of their own inadequacy. Thus women could avoid questioning their social situations and addressing the content, quality and meaning of their lives.

3.1 Depression explained as a biological/ hormonal problem

Two women, Jean and Penny, explained their experiences of depression as hormonal. They thus validated their problems through offering a biological explanation, but constructed themselves as pathological, irrational and out of control, as deficient by virtue of being female. Through the concept of pre-menstrual syndrome or pre-menstrual tension, depression becomes a symptom of pathological hormones, and being female becomes part of the pathology of depression.

The construction of pre-menstrual syndrome (PMS) as pathology can be seen to override the alternative construction contained within women's accounts, of social problems which are part of everyday life. Using the notion of PMS a woman can be

constructed as the victim of her hormones, with no regard to the subjective meaning of her experiences.

Penny used an hormonal explanation of depression to explain and to validate her experiences of depression. She legitimates her experiences as pre-menstrual and real depression. The concept of PMS provides a way of explaining and validating her experiences through biological dysfunction.

Penny: I am bad with my monthlies and things like that. And get really depressed and, you know, and really down then, and I don't want to go anywhere you know...
Siân: Is the depression, you know, like when you get depressed, when you have a period, is that different to - I don't know, when you were depressed when the kids were little?
Penny: I think these days it is different, 'cos I just - I think it's different in a way because I just want to, there's nowt that I want to do, I don't want to go anywhere, I don't want to set foot outside door you know, really.
Siân: Yes. How do you manage with Jo and Julie?
Penny: I have to carry on, don't I? I have to do. I don't want to but I have to. So - take 'em.
Siân: Have you ever gone to your GP about -?
Penny: Oh, I'm under clinic and doctor's and I'm just taking, you know, vitamin B6 and I think it's helping me. I think I'm alright, but he [her husband] says, and I ask his opinion and he says I'm just same really, because I feel right aggressive and that, and I'm right nasty when I'm like it. Doesn't sound like a good life does it?! And er, I can be, like, unwell for nine days -
Siân: Oh, that's a lot.
Penny: Then it used to be like a fortnight before I'd start feeling nasty and everything, but that's sort of calmed down a little bit with vitamin B6. But when I'm on a period I'm really up wall you know?

Implicit in Penny's account is an alternative explanation of depression in terms of the stresses of her life. Penny herself draws attention to the poor quality of her life. For example, she is unable to meet her own need for rest. But the available hormonal explanation reduces the problem of depression to female pathology. In explaining her experiences of depression as pre-menstrual, she marginalises her own implicit account of her *experiences* as depressing.

Constructions of depression as hormonal shift the focus, from explaining depression through problems contained in the lives of women, to explaining depression through conceptualising women as pathological by virtue of being women. Such constructions implicitly identify all women as potentially pathological.

However, an explanation of depression as a symptom of PMS also offers women validation and the hope of resolution of their problems. It offers women the possibility

of medical help, through a medical discourse which may be the only available recognition of their distress. It may also offer a construction of depression which is more acceptable, to women unable to change their lives, than a conscious recognition that their difficulties lie in their experiences and relationships.

Drawing on Giddens' work on the structure of knowledge (see Chapter Three, Part II, section 4.3) as discursive or conscious knowledge and tacit and unconscious knowledge, depression may be discursively validated as conscious knowledge through the concept of PMS. However, interviews such as Penny's contained implicit explanations of depression in terms of the woman's life and relationships, although she may not consciously make this link herself. This is also demonstrated in the excerpt from the interview with Jean, below, where PMS is used as a powerful explanatory concept which distracts from the problems she faces in meeting the demands upon her.

Jean: Yes. And I don't, basically I don't want to upset people. But I know, um, in the throes of PMT you flip, or you can flip, you're more likely to flip, and say the things which you've been holding onto. Things that you want to say, which perhaps need to be said sometimes, but you don't say them. And all this time you've kept control and then phut, you go and you say it and it makes a nonsense of the control.

Jean: And I suffered, um, a lot after Christmas because I'd done something which, at the time, seemed very right, and then afterwards other people thought was wrong. Um, and you see, that's a part of the um, pre-menstrual thing. Because you can do horrendous things under pre-menstrual tension and feel perfectly justified.

The concept of pre-menstrual tension (PMT) is used by Jean herself to explain times when she loses her normal self-control, to explain deviations from traditional female behaviour, when what she says may upset others. It provides a construction through which she can explain, and perhaps better cope with, what she understands as lapses in her behaviour.

Explanations of alternative behaviours as symptoms of pathology may be used to reinforce traditional modes of behaviour as appropriate and normal female behaviour. Using the concept of PMT to construct her behaviour as pathological, Jean's behaviour may be regulated and judged by others as irrational.

PMS may be used by male partners to define women as problematic, and women themselves may use it in taking responsibility for problems within their relationships. Jean's problems are not identified by Jean but by her husband, to her, since he can identify changes located in her which she is unaware of. Penny, in the excerpt above,

accepted her husband's judgement that she was not improving under treatment, although she had thought she was, and his view of her behaviour as problematic. Thus women's pre-menstrual experiences and women themselves may be defined by men as problematic.

Jean: You know, I think my husband's done well to stay with me. Erm, 'cos he has suffered from my problem for, like, twenty-nine years - which is a long time. And he can observe the changes when I am not aware that they're happening. Particularly on the pre-menstrual tension front.

3.2 Rejecting hormonal explanations: explaining depression through women's lives

Ros believed that the term PMS is used to marginalise women and their experiences, so that they do not look for problems in their lives but see themselves as problematic by virtue of female biology. She argued that these explanations are adopted by women themselves to avoid addressing or to hide difficult problems in their lives. Hormonal explanations are available, are simpler and do not challenge the structures of an individual woman's life.

Ros: There was this article about um, describing PMS, and had all this stuff around hysterical women in the Victorian ages - where they ripped their wombs out. So now a different way of describing the anxiety in women's lives is that now you can call it PMS.
Siân: Yes!
Ros: And so you can say, "I'm not depressed I've got PMS".
Siân: Yes.
Ros: And um, can put it all in there that something that's recognisable and acceptable.
Siân: Mmmmm.
Ros: "It's not that I really hate my husband", or um, "It's not that I'm an uncontrollable beast and I can't stand him - I was in the rage of PMS."
Siân: Yes.
Ros: And I suppose it's sort of saying, "Yes, how could anybody put up with it and there was nobody offering me any support". Um, I mean, I think women's lives are really difficult. I think this is a really terrible sexist society that we live in. Um, (sigh)... Um, and I mean, like, to have something like a women's disorder, I mean, just seems like the whole, I mean, why should it be so different just based on your gender? Like your gender rules your whole being, your whole life.

Similarly, Fran rejected the concept of post-natal depression. She believed that the problems she experienced were on-going, complex and long-term issues in her life, which had been brought to a crisis by the changes involved in the birth of a child, and could not simply be explained in terms of hormonal change. Fran explained depression as a process of change and adaptation.

Fran: It's not so much, um, I don't think having, like a lot of people say when you have a baby and all this post-natal depression thing, it's like a hormonal thing when you have a baby - I think it's just a load of rubbish.

> I do think all them things were there before I even had a baby, it's just major events in your life - births, deaths, babies, er, any major thing like that just brings up a lot of different things.

Fran and Ros sought to make sense of depression in terms of their own lives. They rejected explanations of depression as hormonal, explained depression in terms of problems in their lives and were actively engaged in making changes in their lives. The rejection of socially powerful explanations of depression as pathology may empower women to address problems in their lives. By locating the problems in their lives rather than in individual biology, women may be empowered to act upon those problems and effect change in their lives.

3.3 Coping

Women interviewed suggested that depression is recognised as a problem when individuals feel unable to cope anymore. There was a strong theme throughout interviews that women knew they had a problem when they were no longer able to cope, and also that they saw themselves as inadequate because they could no longer cope. There was some ambivalence as to whether the woman herself was inadequate because she could not cope with her situation, or whether her problems lay in her situation.

Tina suggested that people should seek help for depression when unable to cope:

> Siân: If someone's depressed, at what point do you think they should actually go for help?
> Tina: Well presumably when they feel they can't cope any more.
> Siân: Yeah.
> Tina: I mean there is a point when people with a reasonable intelligence know that they're not functioning efficiently anymore and when -, once that's registered, and it's registered two or three times, "I'm still like it, I haven't improved", you know, then someone who's got any common sense thinks, "Well I've got to have something, I've got to do something about this", right?

Fran sought help when she felt that she could no longer cope with her daily life. She implies that the problems lie in herself, and not her situation. She identifies as a personal issue the difficulty of coping with childcare and her isolation with the children.

> Fran: And I've had to seek help, you know, like Health Visitor, I was phoning them to say, "Look I can't, I've got a lot of emotional problems so the practical things just um, I can't cope with them, you know. I can't cope with getting up and not having, all I've got all day is kids."

Jean is unsure whether her problems were due to the pressure she was under or her pathology. In her account of the onset of depression she lists the pressures she was under at work as factors in causing her depression, but then suggests that the treatment she was under indicated a biological problem, that she was inadequate.

Jean: About, oh dear I'll have to count this back, about thirteen years ago I was in full-time teaching, my children were, sort of, eleven and thirteen years in age, I was preparing to move from one area to another area which were about two hundred miles apart. I was working a five and half day week because the school I taught in was a day boarding school, so although I was a day member of staff, I had to do weekend work as well. So I'd got quite a heavy load and um, I suffered what was described as clinical depression and various drugs didn't improve the situation. So my doctor sent me to a psychiatrist -

Siân: Yes.

Jean: - who said he would er, try lithium, which is a drug that they prescribe for manic depressives. And it seemed to do the trick so um, whether that meant that I never had clinical depression in the first place or I just suffered a breakdown because of the pressure I was under, or I am basically a manic depressive - at the low end of the scale - type, I don't know.

She later expands this, suggesting that both genetics and circumstances can combine to cause depression. Her daughter had committed suicide about eighteen months before the interview. (The genetic explanation may also be powerful in explaining her daughter's depression and eventual suicide to her).

Jean: That I have a gene which I have inherited from my father which predisposes me to manic depression... So the wrong pressures, um, the wrong stresses, a particular time of life suddenly sparks it off. So in another person the gene might be there, like the gene might be in my sister but it's never materialised. The same gene could be in my elder daughter, but, and it might be in my younger daughter, but because of the rest of her personality and the type of person she is, they way she handles the stress, it won't, perhaps, ever materialise. I don't know.

Hilary suggests that if she was not depressed she would be able to deal with the problems in her life. It is depression which is preventing her from coping with her problems, rather than problems in her life which are leading her to be depressed. Her depression is a sign of her own weakness and inadequacy, and it is because of this that she cannot leave her husband. However, she had earlier explained her depression as caused by her husband's treatment of her.

Hilary: Mmmmmm. I don't know. I suppose I wasn't strong enough about this [leaving her partner]. I suppose the reason I wasn't strong enough was because I was quite depressed.

There is contradiction and confusion in Hilary's use of the term "depression", since she attributes her experiences of depression to her life circumstances, explaining it as reactive depression rather than endogenous depression. Thus she can construct depression as a valid reaction to problems in her life and so avoid pathologisation.

> Hilary: I feel like I have reactive depression so-. You know, like you get endogenous depression where it's inside you but I just feel as though I've reactive depression because of the situation, you know? It makes me feel a bit better you know, that I'm not totally mad. You know, that I'm not, that it's just my situation, you know, that's making me like this.

4. The process of help seeking: a contradictory relationship with medical authorities

A contradictory relationship with the medical authorities is suggested in Cate's account of a G.P. consultation, which she sought because she no longer felt able to cope alone and needed help. Her G.P. is her only available source of help and he is able to legitimate and recognise her problems. Although she does not see her experiences as pathological, she is left feeling a fraud when the legitimacy of her symptoms is denied and she is told that she is not depressed.

She is in a dilemma, since her G.P. was the only person available to help her but she herself did not see her problems as medical. She was seeking social and moral support but not medication. His refusal to validate her problems as depression leaves her feeling rejected, devalued and worthless: she sees herself as stereotyped as an ex-drug taker. As a result, she doubts the validity of her problems and wonders whether they were all in her mind or imaginary. She also has no alternative help available.

> Cate: I mean, I went to the doctor about it because, like, you know, I was a single parent. I'd just got married, I was trying to cope with Ben and he was a real handful. I used to have a drug problem like, before I had been, I was quite lucky that I stopped taking drugs just before I got pregnant. I stopped taking drugs, you know, because the amount of... and I'd just moved up to X [town] as well, so I was like really isolated. After I had Ben I was like, you know, sort of holding myself together for him, you know, and that was really demanding, but when he got to about a year I just got to the stage where I didn't think I could cope because of all the changes, you know, that I had gone through in my lifestyle. I felt like I'd just reached, you know, the point of no return kind of thing. Yes, so it was all in my notes and everything about my drug problem in the past... And I sort of told him that I was feeling really down and I couldn't cope and everything and he just sort of said to me, "Well, do you think you're depressed?" and I was like, "Well, yea, I do", and he's like, "Well I don't think you are" and "Just kind of get on with it", you know, "Things'll get better". "If you still feel like this in a month then come back", you know. So I like went back again about it, but he just said the same thing. He just made me feel like. He said to me, "Is it drugs you want?" and I was like, "No, no, I've had a drug problem and I've got a two year old child,

> I'm not going to start taking drugs again". It was just a case of that's how he looked at me... Well, that's the way I felt, that he was looking at me as like, you know, a sort of junkie and I was just like trying it on to see what I could get... or something. When like, my self-esteem's at rock bottom anyway, but to be treated like that, whether it was in my mind or not, you know, just made me feel ten times worse.

Cate, having been told by her G.P. that she was not depressed, has difficulty in validating herself as depressed. She attempts to construct a discourse of depression which is alternative to the medical discourse. However, she is unable to construct her problems as real and explains her depression as self-obsession. This implies that she is weak, drawing upon a moral discourse, rather than that she is facing real problems. It is difficult to validate depression without using the powerful medical discourse of depression as pathology, and it is difficult to reject the medical discourse or to construct an alternative discourse of depression to the medical discourse.

Siân: Any other about what you'd call depressed then as opposed to feeling down?

Cate: I don't know. I think, 'cos I've got like, stuck in my mind what that doctor said it's like. Yea, I think I do get depressed sometimes actually. I do like become like self-obsessed. I don't know if that's the right word.

5. Summary

Some women interviewed were reluctant to call themselves depressed and avoided this through sometimes retrospectively identifying depression, sometimes avoiding the term "depression", or sometimes defining themselves as not currently depressed as against cases of "real" or more severe depression. For example, Cate said that she was not "really" or clinically depressed, and did not need hospital care.

The label "depression" may be potentially damaging, because it defines women as inadequate. This is particularly so for women in their roles as wives and mothers, where women stereotypically care for others and meet their needs in doing so. To be depressed may mean that a woman has failed as a carer of others, and as a woman because her own needs have not been met through caring.

The recognition of depression may define a woman as inadequate as a woman, as a wife and mother. Women may avoid seeing themselves as depressed because this would be to construct themselves as failures as wives and mothers. For example, Cate discursively avoided the notion that she was depressed, or conscious knowledge of her depression (Giddens, 1979), because she believed she had to care for her family and that seeing herself as depressed would hinder her from doing so.

The label of depression as a medical category, as a clinical state and as pathology, may not be seen by women as appropriate for what they experience. Women may thus avoid using the term depression because it carries a medical or clinical meaning which they do not relate to their experiences. But the problem may be that there is no available discourse through which women's experiences are validated. There is no recognition that their lives are problematic as mothers, since this is inconsistent with the social construction of motherhood as a non-problematic ideal.

Women may reject the notion of depression as a symptom of pathological female biology, and draw attention to problems within their relationships, lives, circumstances and experiences, which they may or may not see as depression. For example, Ros and Fran used the term "depression" but they redefined it in terms of their own experiences, and rejected the pathologisation associated with depression. Ros was reluctant to use the term "depression", but in doing so reconstructed an alternative discourse of depression as a complex and on-going aspect of her life experience. Fran reconstructed depression as an opportunity to reassess her life and, in terms of her own experiences, as a dynamic experience. They reconstructed depression as a dynamic and meaningful, rather than a static or pathological, state. Both Fran and Ros rejected the concept of post-natal depression. Ros rejected the medical approach to depression as categorising depression in a way which did not relate to personal experience.

Through the medical discourse, women may be constructed as either inadequate women or as pathological. A diagnosis of depression is pathologising, but it may be the only available recognition that a woman has real problems, since there is little recognition of difficulties in daily life. This is seen in Cate's account of her consultation with her G.P., when she felt that her problems may have been imaginary because he told her that she was not depressed. The problem appears to be that for many women there is no available discourse, alternative to the medical discourse, through which to recognise the real problems that they encounter in their lives.

PART III DISCUSSION AND CONCLUDING POINTS

Powerful discourses and defective women

Female hormones may be seen as pathological. Depression in women may be explained through the pathology of being female. Jean and Penny explained "real" problems of depression through the notion of PMS. This constructs all women as potentially problematic and being a woman as part of the pathology of depression (Ussher, 1989, 1991).

The availability of a discourse of defective female biology, which is produced, reinforced and sanctioned by the practice of medicine (Ussher, 1989, 1991; Nicolson, 1991), means that all woman may be defined by men as potentially pathological. Within their relationships, men may define women as the problem. The discourse of defective reproductive biology reinforces women's powerlessness within relationships. Penny's and Jean's husbands both defined them as defective and pre-menstrually problematic, definitions which Penny and Jean accepted even though Jean was not aware of having problems and Penny thought that she was improving.

Powerlessness was thus experienced at an interpersonal and socio-structural level. As has been shown, some women, such as Ros, were aware of problems at a social and structural level, but individually were left relatively powerless and frustrated in efforts to change their lives without adequate social support. This emphasises the importance of recognising both the commonality of experiences and the real problems of powerlessness faced by individual women. Women did experience themselves as relatively powerless. For example, Fran had become aware, when her relationship with her partner was breaking down, that she needed to act autonomously and act for herself, breaking out from dependency on relationships. However, she was unable to study, because of the demands of childcare. Similarly, Cate gave up an Access course because she was unable to both study and look after her son with little support from her partner.

In Jack's terms a patriarchal "Over-Eye" (Jack, 1991, p.133) constructs women as objects and discounts the values and worth of female experiences, based on male experiences and values (see Chapter Three, Part II, section 5.2). Women's powerlessness is constructed in relation to a "generalised other" (Mead, 1934) redefined as reflecting the male values of patriarchy, common social values against which women are judged as defective. It is incorporated into gender identity at a personal and interpersonal level.

Women are positioned between two contradictory extremes, as either morally idealistic or biologically flawed. In contrast to the moral idealisation of women as mothers, women may be constructed as defective by virtue of being women in terms of their reproductive biology. These extremes leave no room for the realities of women's experiences. Women measure themselves and are measured by others against the romanticised ideal of motherhood. Against this their experience can only be problematic, and it is they themselves rather than the social construction of motherhood which is seen as problematic. Women are constructed as defective by virtue of being women, through their biology. This leaves little room for them to validate their experiences as problematic.

Women may not see the term "depression" as appropriate to descriptions of their experiences, because it has pathological and clinical connotations. They may understand their problems in terms of difficulties in their lives as mothers, within a moral rather than a clinical framework, and themselves as poor mothers or not "good" enough women. Recognition of a clinical problem of depression may validate their problems but at the same time define them as pathological, as not good enough through pathology rather than personal weakness. The choice between discourses of pathology and personal inadequacy does not allow women to validate their experiences in terms of the problems of their everyday lives.

Several things might be helpful in explaining women's experiences of depression. Firstly, recognition of the commonality of their problems as *part* of motherhood, refocusing on social issues rather than the level of the individual, may empower women by moving beyond their individualised experiences of motherhood and depression. This might be achieved through support groups such as the group where women in this study were interviewed, for women who are otherwise isolated. Secondly, the concept of depression might also be extended to take account of what women actually do experience as depression, moving beyond the clinical focus on biological issues and depression as individual pathology. This might facilitate women in validating their experiences as depression, and by extending explanations of depression beyond the biological and pathological might lead to the development of more appropriate forms of help.

CHAPTER NINE:
A DISCUSSION OF ISSUES EMERGING ACROSS STUDIES

PART I INTRODUCTION

In this chapter, common themes emerging from all four studies will be discussed, focusing on the social construction of depression and what is actually experienced as depression. The theoretical basis and contribution of the thesis is developed. Drawing on symbolic interactionism, an explanatory framework for the social construction of depression is developed, looking at depression as subjectivity and as a socially constructed reality, and identifying powerful discourses incorporated into interpretations of subjective experiences of depression.

The four studies were based on data from 76 interviews. Study I was based on 20 interviews with 36 participants drawn from a university population, and focused on their beliefs about depression. Study II was based on 9 interviews, interviews with 6 psychiatric out-patients and 3 patients of general practitioners. Study III was based on interviews with 26 health professionals about their understandings and experiences of depression, and the data analysis presented in the thesis was based on interviews with G.P.'s, psychiatrists and clinical psychologists. Study IV was based on 21 interviews with women about their experiences of motherhood and depression.

Themes are discussed in this chapter drawing on data from *all* the studies, to emphasise common features of experiences of depression, whereas earlier in the thesis data has been analysed within each study. While the four different studies presented in this thesis have differed in the results which they have produced, commonality has also emerged. This is particularly true of the studies based on accounts of subjective experiences of depression, Studies I, II and IV. Similar or common themes have been identified throughout the studies in the ways in which individuals account for and explain their experiences of depression, despite the differences in sex, age, patient status, and in individuals' experiences. Study III is discussed in terms of the commonalities and differences between health professionals' accounts of depression and accounts of subjective experiences of depression.

Each study has had its own emphases and aims. However, the analysis of data was a continuous and recursive process and developments in one study, both substantive and methodological, informed other studies (see also Chapter Four). The studies were mutually informative. Approaches and questions for research were developed through

the process of research, since questions which emerged earlier in the research process were developed in subsequent studies.

Common themes in accounts of experiences of depression are discussed in this chapter, using material from all the studies discussed in this thesis. Issues discussed in this chapter include:

1. Subjective experiences of depression. These are considered in terms of relationships to others, the construction of self, and difficulties in communicating feelings of depression.
2. Interpretations of experiences as depression. These are discussed in terms of reflexivity, explanations for depression, and the power of the medical discourse in defining and constructing problems of depression.
3. The construction of depression as a medical problem.

PART II ISSUES EMERGING FROM INTERVIEW ACCOUNTS OF DEPRESSION

1. SUBJECTIVE EXPERIENCES OF DEPRESSION

Subjective experiences of depression were often described in terms of a person's relationships with others. Depression was described as an experience of difference, a sense of being different from other people, and cut off from and unable to communicate with other people. Depression was also often described as an experience of individuality and an experience of a more real or truer self, which was only experienced when alone. Depression can thus be conceptualised as an experience which while an isolated, personal and to some extent private experience, is interpreted with reference to social experiences and social context. Depression is described in terms of relationships with others, or more precisely the lack of meaningful and intimate relationships. Feelings of powerlessness and vulnerability formed part of the experience of depression, and these were also described in terms of relationships with others.

These common elements in the experience of depression are discussed in this chapter in terms of symbolic interactionism. A symbolic interactionist approach is used to interpret accounts of subjective experiences of depression, and to explain subjective experiences of depression in terms of relationships with others. The construction of meaning through relationships, which incorporate wider social values, is considered.

1.1. Relationships to others and experiences of self

1.1.1 Feelings of apartness, being cut off from others

The experience of depression was described as an experience of feeling apart from or cut off from other people. This suggests that depression is located in the self, but in a self which is apart from others. It is a distinct experience which is not one of isolation so much as one of a reality contained within oneself.

Ann, in *Study I* , described feeling apart form others even though with them:

> 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.

David, in *Study I* , quoted his sister saying of her experiences of depression:

> David: "I feel as if I am so remote from people and that I am losing out because I am trapped".

Douglas, a psychiatric out-patient interviewed in *Study II*, found his own behaviour when depressed strange, because he avoided meeting with other people, in contrast to his previous involvement in community work:

> Doug: It's 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.

In *Study IV*, Fran described her difficulty in communicating and interacting with other people. She felt completely cut off from others:

> Fran: So you do feel so distant from people because you're not really on the same wavelength. You're off on some other planet half the time, you know?

Tim, *Study I*, described depression through a metaphor, in terms of being unable to relate to others, although surrounded by others:

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.

Ros, *Study IV,* using a metaphor of a train, described feeling cut off from others, feeling unable to control this, or to get back in touch with or to participate in positive interactions with others:

Ros: And that's a very important part of it, to be able to receive the love that might be available - or the outside impetus that might be available to you... The outside, yes. I think you can be, like being in that room is kind of like a little booth in the world, and you're out there and you've partly got yourself cut off in this way and um - ... I keep thinking of this advert for, you know, like happy people on the happy train and all the miserable people on the miserable train and um, but it's isolation from the world and not feeling connected with - . I mean, I suppose that's where it can be really important to meet in groups where other people feel like that, but um, the complete isolation that can come just occasionally can happen all the time. You can feel moments of it or you just might feel an anxiety about it.

1.1.2 Feelings of difference and individuality

Depression was also described as a feeling of difference and as an investment in one's individuality.

So for example, Ann, in *Study I,* said of her experiences of depression:

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.

Ann talked of her experiences of depression in terms of her sense of difference 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.

Fran, in *Study IV,* explained her experiences of depression as an opportunity for self-development and an opportunity to become more aware of herself. She explains that in this way depression can be like a gift:

Fran: It can be, you know, because you can learn so much more about yourself after you've gone really in... and then found the strength to come out the other end, you know?

1.1.3. Feelings of powerlessness and inadequacy

Feelings of depression were often described with reference to social context, in terms of relations with others. This suggests that depression can be explained as constructed through relationships with others, following a symbolic interactionist approach where meaning and the self are explained as constructed through interactions with others. Throughout the transcripts, feelings of depression were described in terms of relationships with others, as in the description of depression as an experience of feeling apart from or different to others, above.

Descriptions of feelings of powerlessness in relation to others can be associated with descriptions of feeling cut off from and different to others. Individuals described feeling powerless and vulnerable in relation to others when depressed. For example Mary, *Study I*, described how she felt powerless in relation to her friends when depressed and unable to voice her own needs, partly because she felt vulnerable and marginalised when depressed.

Mary: I can't just criticise what people say to me because, you know, I've got to be grateful for their sympathy, you know, I've got to like respect the fact that they're making an effort, it's so frustrating.
Siân: You, at the same time, yes, do you actually feel quite annoyed with them as well?
Mary: Yes.
Siân: Yes, that must be... But once you get depressed is it... does that make it in itself more difficult to explain to them what you need, what's going on?
Mary: Yeah, because you're like in this vulnerable state and so the other person is... is like higher status they've got more...

The relationship with the medical authorities, who may be a potential source of help in depression, may also be one of powerlessness. For example Cate, interviewed in *Study IV*, described her consultation with her G.P. as an encounter where she was treated as an ex drug-taker, without respect and with no attempt to understand her problems. She left feeling devalued.

Cate: He just made me feel like-. He said to me, "Is it drugs you want?" and I was like, "No, no I've had a drug problem and I've got a two year old child, I'm not going to start taking drugs again". It was just a case of that's how he looked at me. But there wasn't anything wrong... just a scam... Well, that's the way I felt, that he was looking at me as like, you know, a sort of junkie and I was just like trying it on to see what I could get... or something. When like, my self-esteem's at rock bottom anyway, but to be treated like that, whether it was in my mind or not, you know, just made me feel ten times worse.

1.1.4 Summary

Depression is experienced as feeling apart from and different from others, and as feeling powerless in relation to others. This can be related to behavioural approaches to depression, and explained in terms of symbolic interactionism.

In behavioural approaches, depression has been conceptualised in terms of an interactional model, where the behaviour of the depressed person induces low mood and feelings of depression in others, and this leads to increasing isolation (Coyne, Aldwin and Lazarus, 1981; see Chapter One, Part II, section 6). This experience of isolation is consistent with Gilbert's (1992) approach to depression as an experience of powerlessness, as the depressed person is positioned in an out-group. Gilbert (1992) uses a socio-evolutionary model to explain depression as the experience of being in an out-group and as an originally functional and defensive behaviour (see Chapter One, Part II, section 6).

Alternatively, the construction of depression as an experience of powerlessness can be explained in terms of symbolic interactionism, which theorises meanings as constructed through social interactions. (See Chapter Three, Part II, section 2.2). Following Mead's (1934) theory of social behaviourism, where the self is explained as constructed and experienced in relations with others, depression can be explained as a social experience. For example, feelings of rejection and of low status may be incorporated into experiences of the self as inadequate and as powerless in relationships with others, and these feelings may be reinforced through the behaviour of others, in an interactive cycle.

1.2. The self

1.2.1 The uncontrollable self

As explained above, subjective experiences of depression were described in terms of feelings of powerlessness in relation to others. They were also described in terms of powerlessness over oneself, feelings of being out of control and taken over by depression.

Some participants described depression as an entity, located in the mind or head, which took the person over. This is a notion of being attacked from within, by something which is located in oneself and which attacks oneself, as one loses control over oneself. For example, Mary in *Study I* said of her experiences of depression:

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.

Ann, in *Study IV*, described her experiences of depression:

Siân: Could you say how depression feels? What it feels like?
Ann: It's just dreadful because whatever you do you just can't get away from it. You lose a right lot of energy, no energy to do anything at all. You just feel so lazy.

The attack from within is also described by Ros, a mother in *Study IV*, who talked of being cut off from herself through being overwhelmed by one part of her experiences:

Ros: And is um, it's like of, like a sombreness. Um, I'm trying to sort of look for this emotionally, rather than intellectually, like where I feel it and things like, kind of like being out of touch with your love and your spirit and -
Siân: Yes.
Ros: Um, or out of touch with parts of it, so you're just overwhelmed by one part of your feelings, so that it like overwhelms many parts so that, when the body can slow down and feel lethargic, and you're spirit can feel lethargic so you're unable to laugh and unable to love and that can diminish so much, but be unable to express it.

Depression is feared because it is apparently irrational. The fear of depression is also a fear of oneself, since depression is an individualised experience for which no external reason can be identified, and through which the self is constructed as irrational. Ann, *Study I*, suggested that although she is no longer depressed she fears that she will become depressed again and is fearful of her own emotions and moods. While she feels vulnerable to depression she can never trust herself:

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.

Thus in depression one may feel powerless over oneself and unable to trust oneself.

1.2.2 Depression described in terms of a change in self

Depression was also described as a changed experience of oneself, in comparison with how one used to be. For example Douglas, an out-patient interviewed in *Study II*, described the very different ways he now behaved in comparison to his behaviour in the

past. He said that, while he still felt the same person as he had before he had became depressed, and while he would not have lived his life differently, he had now lost all his motivation and interests in life.

> Doug: 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. I have to make myself get out of bed.

Martin, also an out-patient interviewed in *Study II*, described his loss of confidence and change in behaviour compared with how he used to feel and behave.

> 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.

Accounts of subjective experiences of depression (section 1.1, above) suggest that depression is constructed through interactions with others, as an experience of being outside meaningful interactions or relationships. Depression is described in terms of changed relationships with others, changed patterns of behaviour and a changed sense of self. Individuals experience themselves as different to others, behaving differently to how they used to behave and experiencing themselves differently.

Descriptions of depression in terms of changed relationships, behaviours and experiences of self, are consistent with Meadian social behaviourism (Mead, 1934; see Chapter Three, Part II, section 2.2), where the self is explained as experienced through internalising and reflecting upon the behaviour of others. Depression may be explained as a changed experience of self in relationship with others, constructed through reflection on social experiences. Experiences of depression may incorporate a changed experience of oneself in relation to other people, as inadequate, as socially isolated and as apart from others. Experiences of depression may reflect the difficulties of negotiating a changed social position or social identity, as for example the difficulties experienced by Douglas when he had retired, and may incorporate a loss of confidence in oneself.

1.3 Difficulties in communicating feelings of depression

Throughout accounts there was an emphasis on describing behaviour rather than feelings or emotions. Nicolson (1988), using in-depth interviews with women about their experiences of depression in the post-natal period, similarly found that depression was described in terms of behaviour rather than emotions. Describing how it felt to be

depressed was difficult, if not impossible. For example, Douglas, an out-patient interviewed in *Study II,* said in response to a question about how it felt to be depressed:

> Doug: It's 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.

Martin, an out-patient interviewed in *Study II*, also suggested that depression was an experience 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.

There are a range of possible reasons for difficulty in describing how it feels to be depressed. There may be no available language to describe how one does feel in depression, or people may see negative feelings as difficult or socially inappropriate to talk about.

Douglas, interviewed in *Study II*, felt that he could not tell his wife how he felt when he was depressed because she would be unable to cope with the difficulty of his experiences.

> Doug: Yes, because I don't feel as bad as I did when I first started to come, you know. But I don't mind coming here, you know, talking to Dr. Wright... I wouldn't do that to anybody else... I don't tell the wife and that, I bottle it all up.
> Siân: Yes. Why? Why do you think that is?
> Doug: I don't know... I don't want to upset her anymore than what she seems to be upset, in knowing that I'm not too good, you know.

Ann, interviewed in *Study I,* suggested that the difference of depression from other experiences is problematic. She considered, based on her own experience, that depression is an experience which is difficult to remember once it is over. She experienced herself very differently when not depressed compared to when she was depressed. Depression may be a state which is difficult to relate to other experiences, since it constitutes a very different experience of self.

> Ann: It's very, very difficult, it's like talking about a state which you just virtually can't remember it, 'cos 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.

1.4 Summary: experiences of self in depression

Difficulties in describing or remembering feelings of depression may be consistent with Mead's (1934) notion of the self, where the self is conceptualised as the "I" and the "me". The self is explained as the "I" spontaneously acting and the "me" arising as an object through taking the attitude of others, in reflection on past action. (See Chapter Three, Part II, section 3). The self experienced in depression becomes an object to the "I" retrospectively, when the experience of depression is past.

However, depression may be difficult to interpret or describe since it is experienced as individualised. Experiences of depression may be inconsistent with shared social experiences and outside the forum of common social experiences and shared social discourses. It may be that there is no language available to describe depression, an individualised state which is not shared though common. As an individualised aspect of the self, depression is difficult to objectify within available, shared social discourses. As a dynamic experience of self, it may represent an experience of the self cut off from processes of social interaction.

The difficulty of constructing accounts of depression using available social discourses indicates a major problem in this thesis: the difficulty of researching subjective experiences of depression, even using qualitative research methods, when depression is something which it is difficult to describe. However, this also indicates one conclusion from this research, that depression *is* difficult to describe. Taking a symbolic interactionist approach, this difficulty may indicate that depression is an experience of a self which is outside the limits of everyday social interaction and discourse. Following a symbolic interactionist approach, depression may be an experience of "other" which is different to the "generalised other" of shared or, as interpreted in this thesis, dominant social values (see Chapter Three, Part II, section 5). It is an experience of oneself as "other", as unacceptable to other people and often to oneself. It may be that depression is difficult to talk about, describe or make sense of because it is an experience of a self outside the forum of shared experiences.

Depression was described as feeling cut off from, apart from or different from others, and unable to relate to others (see sections 1.1 and 1.2, above). Recovery from depression may involve becoming involved with other people, and feeling that one is acceptable to others. For example Ann, interviewed in *Study I*, said that she did not think she would become depressed again because she no longer felt different to other people (section 1.1.2 above).

Fran, interviewed in *Study IV*, saw depression in terms of withdrawal and the solution to depression as re-engagement with others, taking responsibility for oneself in relationships with others. She argued that depression was an opportunity for self-learning, through taking responsibility for one's own actions, and for one's relationships with other people. She implies here that coping with depression and moving out of depression is achieved through realising one's own responsibilities and power.

Fran: In some cases people can, like, say if you've been sexually abused then yes, you've got a lot of reason to say, "Right, that is", you know, erm, "You did this to me" or you know or whatever. You can blame people to a certain extent but I don't think um, I do think you can learn a lot about yourself through your depression. A lot about yourself and at the end of the day you can have a lot more confidence than you ever dreamed that you would have before.

Siân: Yes.

Fran: If you can manage to get through it. And you get stuck if you're putting blockages up to thinking that, you know, "This person made me feel this and that person made me feel like that". As if you've got no part to play in it. When you're still involved with other people, you know, you're still part of other people and trying to understand, you know, why people might be like that to you and like, you know, what you give off and how you appear you know.

2. INTERPRETATIONS OF EXPERIENCES AS DEPRESSION

Whether individuals interpret their experiences as depression, and what they mean by the term "depression", are important considerations in investigating accounts of subjective experiences of depression. Individuals identified and attempted to explain their experiences as depression in interview accounts, drawing upon available discourses. Analysis of data from all studies suggests that in accounting for experiences people both draw upon and are constrained by available discourses. Individuals use and reject available discourses in constructing contradictory accounts of their experiences, which indicate that there may be underlying meanings which are not simply contained within available discourses. Individuals may also attempt to construct alternative discourses or reconstruct and give new meaning to existing discourses, as they account for their experiences as depression, but this is seen to be difficult.

The medical discourse, through which depression is constructed as a medical problem and as an illness, is a powerful discourse, as seen in interviews with patients (*Study II*) and non-patients (*Study I* and *Study IV*) and health professionals (*Study III*). But the medical discourse is also rejected by individuals as inappropriate in accounting for their own experiences. It carries values with which individuals may not concur in interpreting their experiences as depression, and in constructing these experiences as meaningful. On the other hand, it is difficult to construct alternative discourses to the

powerful medical discourse of depression, by which depression is validated as a problem but not a medical problem.

Individuals are seen to contradict themselves in accounts where they identify themselves as both depressed and not depressed, as they position themselves in relation to the medical discourse and seek to avoid the pathological implications of that discourse. Some individuals attempted to explain their experiences of depression in constructing alternatives to the medical discourse, and explained depression as a personally meaningful experience.

Once an individual had distinctly identified depression as a problem, depression was constructed as an entity, as something which had happened *to* the individual. Individuals referred to their situations and to themselves as problematic as they attempted to make sense of and explain experiences of depression. But depression itself remained a mystery and there were no satisfactory explanations available. It is difficult to construct an alternative discourse of depression, through which *depression is* constructed as a meaningful experience.

2.1 Identifying depression

2.1.1 Recognition of depression: the relief of identifying the problem

There may be a sudden crisis point at which individuals realise that there is something wrong and begin to identify themselves as depressed. Karp (1994), in research on patients' subjective experiences of depression, found that there was a crisis point at which an individual recognised that problems were not explicable only in terms of his or her situation, and that the problem might be his or her self.

Thus the diagnosis of depression may provide a point at which a distinct problem is identified to oneself, and located in oneself. The recognition of depression as a medical problem validates it as a real problem. The categorisation of depression as a problem, although a problem contained in oneself, may ironically be powerful in validating sense of self since the problem can be distinguished. The diagnosis might come as a relief, a recognition that there was a real problem, that there might be help available and a potential solution. For example, Angie, interviewed as a G.P. patient in *Study II*, said of her reaction to the diagnosis of depression:

> 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.

Margaret, interviewed in *Study IV*, realised that she was depressed after the birth of her third child and that she had previously been depressed, although she had not recognised her depression previously. She was able to recognise depression, as a changed and also a familiar experience of self, through retrospective reflection on her past experience. Identifying depression as the problem enabled her to deal with her current experiences.

Siân: Would you say that most mothers do, at some time, suffer from depression? Or is it all part of the process?

Marg: I wouldn't - from what I've seen over the years I would say yes... The one thing I would also say with that, is that they don't always know they're depressed. I mean, I didn't at first. I mean, it was only really, um, when I got to grips with myself after my third one had been born, um, and when she was about three years old I suddenly thought, "I've been here before". And it suddenly struck me that, um, the lethargy I was feeling and the lack of action, um, and the way, um, it took me so long to actually do something that should have taken me half as long, that I was depressed. That was actually great. You need labels.

Fran, a mother interviewed in *Study IV*, said that she was only retrospectively aware that she had been depressed at times in her life. It may be through moving through her experiences of depression that she can now say that she had been depressed. (She did not see depression as a finished but as a recurring experience, and described herself as feeling very "positive" at the time of interview.)

Fran: You can learn so much more about yourself after you've gone really in... and then found the strength to come out the other end, you know? So I think, um, that I can look back on my life now and see times when I was actually depressed but never acknowledged it...You know, I didn't have any enthusiasm. I used to sleep ever such a lot, which I think's a sign of depression - sleeping a lot - no motivation to do anything. And not doing much with your life and, er, and then it was really when I had Clive, my first one, three years ago, when everything just hit me.

2.1.2 The meaning of the diagnosis: Pathologisation and stigmatisation

Tina, a volunteer interviewed in *Study IV*, suggested that medical help was stigmatising since it implied that the person was unable to cope with depression. She suggested that it is this inability to cope with depression which is stigmatising, rather than depression itself which may be accepted as part of life.

Tina: You hide it rather than come out with it.

Siân: It's almost as if there's something wrong with you in a sense there isn't if you've broken your leg.

Tina: Yeah, in the fact that you can't cope with something, you haven't made yourself ill, but you've got this thing and now you can't get out of it, therefore you can't cope with it. And that's the thing that you don't want

> people to find out about, not necessarily that you've got the illness in the first place but that you can't cope with it.

Individuals may fear being seen as weak by other people, because depressed. A diagnosis of depression may define individuals as pathological, both to others and to themselves. Individuals may avoid telling others that they are depressed. For example Chris, interviewed in *Study II*, described his reaction to the diagnosis of depression. He told his wife of it with difficulty:

> Chris: I think really I was quite shocked and I didn't know how to tell my wife.
> Siân: Did you tell her?
> Chris: I did yes - 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.

This excerpt can be interpreted in two ways. Chris may have feared the diagnosis of depression as pathological, and he rejected it elsewhere in the interview as incompatible with his interpretation of his experiences. He may also have dreaded telling his wife, since she was part of his life and, if he was depressed, might then see herself as part of the problem. The diagnosis of depression may be pathologising because it contains the problem within the individual but, on the other hand, it may be used to construct the individual's lifestyle and relationships as at fault, as inadequate or implicitly pathological.

Angie, interviewed in *Study II*, described her own and her husband's friends as having been "good" because they had accepted her depression. However, she has to negotiate her acceptability with them through humour:

> 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.

2.1.3 Rejection of the medical discourse of depression as pathology.

The notion of depression may be explicitly avoided in discourse, although there may be an implication that the person is depressed and is avoiding conscious knowledge of depression. This provides support for Giddens' (1979) distinction between discursive or conscious knowledge and unconscious or repressed knowledge. (See Chapter Three, Part II, section 4.3. See also Chapter Eight, Part II, Part C, section 2.1.1).

Cate, interviewed in *Study IV*, understood real depression as a clinical problem, and her own experience as not "real" depression:

Siân: Have you ever been depressed?
Cate: Have I ever been depressed? Well, I've been, well yea, not right down, I suppose, like clinical depression or anything, no. You read about, you know, people who have to like go into hospital, you know. I haven't had it like that, just suddenly things get on top of you and it don't seem like there's any way out of it and it's just like a downward spiral, you know.

Cate refused to call herself depressed, because she believed that she would then be unable to cope with her roles and functions in relation to others. She described her situation as difficult because she was trying to care for both her husband, who was schizophrenic, and her son, who was a very active child. While she felt down about her situation, she suggested that calling herself depressed would add to her difficulties. However, she believed that she could acknowledge her problems when talking to other women. This may be because other women provide some support, in a non-pathological context where problems are shared and recognised as common rather than constructed as individual problems.

Cate: Difficult, you know, because I've got Ben [her son]. He's at a really difficult age and really demanding and then I get worried about Jim [her husband]... bit down about that. I won't say it's depression. I don't know, you can't let yourself. I don't know, I suppose you're like sub-consciously trying not to let things get you down because if I go down then there's nobody for them. So you have to try and push it out of your mind. I think when you've got other women to talk to you can let yourself go.

"Depression", validated as a real problem, but not necessarily a pathological problem, may be an escape individuals feel they do not deserve. Ros, *Study IV*, who rejected the notion of depression as pathology, had felt that she was not entitled to ask for help when she felt low nor to voice her personal needs.

Siân: Have there been times when you have felt it was wrong to ask for help?
Ros: Um, well, sort of, socially obliged to um, that it wasn't OK to, or that I'd brought my personal stuff, you know, like I was supposed to be a coper-.

Conversely, the medical discourse or diagnosis of depression may be pervasive and powerful precisely because depression is a problem which is commonly denied, for which individuals blame themselves, and for which the medical discourse provides recognition and validation.

2.1.4. Contradictions in accounts: Difficulties in constructing an alternative discourse of depression to the medical discourse of depression as pathology.

The medical diagnosis is powerful in identifying, validating and legitimating experiences as depression, through the diagnosis. Individuals who reject the powerful medical diagnosis of depression may have difficulty in validating their experiences as real problems. They may have difficulty in constructing alternative discourses to the medical discourse, through which they can account for their problems (Nicolson, 1988, 1992).

Individuals may contradict themselves, in accounts of their problems as both depression and not depression. It is difficult to use the term depression without implying a clinical problem, but at the same time individuals may reject depression as a clinical and pathological construction of their experiences.

Pat, interviewed in *Study II* as a patient of a general practitioner, was ambivalent about whether he was depressed. He saw himself as responsible for his problems and implied that his problems were not real. He can be seen to draw upon two contradictory constructions of his experiences. He constructed his behaviour as problematic and the cause of his depression. He considered that he was responsible for and could change his behaviour, and that he needed to make more effort to go out and mix with people. However, he alternatively constructed depression as the problem and as leading to his unsociable behaviour.

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?

Individuals may attempt to construct a non-pathological account of their experiences while also identifying their problems as depression. But this is difficult, and they may be positioned between two alternative discourses, the medical discourse, where depression is constructed as a clinical and thus as a real problem, and a "moral" discourse, through which depression is constructed as an imaginary problem, as self-indulgence or personal weakness. The medical discourse is powerful in legitimating depression and in locating depression as a clinical problem within the individual. It absolves the individual from any sense of blame or responsibility, through the availability or assumption of a biological or biochemical explanation. The alternative to

the medical discourse may be that the person experiencing depression is seen by other people, and sees herself or himself, as weak or inadequate, with no real problems.

Cate, interviewed in *Study IV,* initially denied that she was "really" depressed, which she saw as a clinical condition. She had difficulty in identifying her experiences as depression. She rejects the idea that depression is selfish but she has no alternative way of understanding depression. The validation of her problems as real and as depression may be an escape which she feels that she does not deserve.

Cate: I don't know, I think I can... you know, being like dumb and that, it's, like, really selfish.
Siân: Do you think it is selfish?
Cate: No, I don't. But I think, you know, that it is, that's what I was brought up with, that kind of idea. You know, I think, like, you get confused about that sometimes. Where you do, like, breakdown and make yourself, and you, sort of, think you shouldn't be doing this, this is wrong.

Cate's G.P. told her that she was not depressed. Cate contradicts her G.P., in saying herself that she is depressed, but redefines depression as self-obsession, implying that her problems are not real. It seems that for Cate it is difficult to construct alternative discourses of depression to the medical discourse of depression as pathology, and to the "moral" discourse where depression is not a real problem but a personal weakness which can be overcome.

Siân: Any other about what you'd call depressed then as opposed to feeling down?
Cate: I don't know. I think, 'cos I've got like stuck in my mind what that doctor said it's like. Yea, I think I do get depressed sometimes actually. I do like become like self-obsessed. I don't know if that's the right word.

Cate constructs her experience of depression as self-obsession, suggesting that her experience is open to interpretation as personal weakness, rather than as a real problem. Pat has difficulty calling his experiences depression and is also self-critical. Both identify ways they behave rather than depression as the problem. They are positioned between a moral discourse, through which behaviour is constructed as inadequate, and a medical discourse, through which a distinct problem of depression can be identified.

2.1.5 Avoiding the medical discourse: The retrospective construction of depression

Individuals may avoid the idea that they are currently depressed. Depression may be identified *only* retrospectively, as a past experience. For example Penny, a mother interviewed in *Study IV,* said that she had been *really* down in the past, implying that she was no longer depressed, although other comments in the interview suggested that

she did currently feel depressed. She was also able to explain her past experiences of depression as caused by a specific life event, her own mother's death.

Penny: I don't know. I wish you'd have come, you know, when it were first happening and everything and then it would have all been fresh in my mind then, you know?
Siân: Is it the sort of thing you actually forget quite quickly or - ?
Penny: I have now because it, well at time it were when my Mum died, you know?

She indicates that she is currently depressed, but that she is resisting this notion. She also believes that others have similar problems.

Penny: Anyway, like I say, when my mum died, I was crying a lot more and everything - but like things have got easier in that sense. I'm not as - that's what I said, if you'd have come at that time, round about that time it would have been different, but like, it's got easier and better - in a way, my life, but yet it's still hard because of these two, money situation and things like that. I mean, I suppose there's thousands out there that's same and that.

Depression may be identified retrospectively, although a person may not have been aware that they were depressed at the time. Subjective experience is open to reconstruction through reflection, as a person and their experiences change, develop and are reconstructed.

Chris, an out-patient interviewed in *Study II*, also identified himself as having been depressed in the past, through a process of reflection on his past experiences and on the meaning of the term "depression" during the interview. He established that he did not considered himself as depressed any longer, in contrast to the past:

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.

2.2. Explaining "depression"

2.2.1 Depression is a mysterious experience

Individuals may avoid seeing themselves a depressed or, as suggested above, it may be easier to identify experiences retrospectively. Part of the problem of depression may be that it is a mysterious experience which is difficult to explain.

For example Chris, an out-patient interviewed in *Study II*, said that he had not considered whether he was depressed until the diagnosis of depression was given by his

doctor. He was told he was depressed, but the diagnosis of depression did not help him to make sense of his experiences.

> 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.

Individuals referred to their situations and to themselves as problematic as they attempted to make sense of and explain experiences of depression. Depression was not acceptable as a problem in itself but was a mystery which needed explaining, both to oneself and to others. Once an individual's experiences had been distinctly identified as depression, depression was constructed as an entity, as something which had happened to the individual. But depression remained a mystery and there were no satisfactory explanations available.

For example, while experiences of depression could be contextualised in terms of some life event, such as retirement for Douglas (*Study II*) and redundancy for Frank (*Study II*), this did not explain why depression had happened to them in particular nor when it had happened. Yet giving reasons for changed patterns of behaviour was important in explaining that behaviour to others. For example, Douglas (*Study II*) said:

> Doug: I've seen them [acquaintances] and I've gone the other way because I didn't want to talk to them and I think that's probably one of the worst things that, you know, I think about it in that respect.
> Siân: Does that make you feel worse after you've done it?
> Doug: Yes, because they can't understood 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.
> Siân: Had you ever felt like that before you gave work up then?
> Doug: No, no, no. No, I never felt like that, as I say, I was always involved.

Depression may be extremely difficult to explain to other people and is usually unacceptable to others. People often find depression incomprehensible, if they can identify no cause, and they may think it irrational. Mary, *Study I*, tried to explain her experiences of depression to other people but found this extremely difficult, because they wanted to know a reason for her depression.

> 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.

Individuals diagnosed as depressed may find the diagnosis of depression unacceptable or meaningless, because it provides no explanation for their experiences. Chris,

interviewed in *Study II,* could find no reason why he should have become depressed and was mystified by his experiences. He was ambivalent about whether he was depressed, and at times explicitly rejected the idea. In the excerpt below, he accepts the notion of depression but can identify no reason why he should be depressed. Elsewhere in the interview he rejected the idea that he was depressed. He also suggested that there might be physical reasons for the lethargy he was feeling, or that he might be suffering from ME, a more acceptable problem which could be identified and explained through reference to physical symptoms and causes.

> Chris: 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.

2.2.2 Explaining depression as individual pathology

By default, and where a problem of depression is identified which cannot be explained through a person's situation or life experiences, depression might be potentially explained through biology or biochemistry. The construction of depression as pathology may be liberating because it absolves the individual from personal responsibility for depression, and offers a potential explanation for experiences of depression which lies outside the moral framework of individual responsibility. The medical diagnosis of depression may carry an implicit explanation for depression in terms of an assumed biochemical causation.

A medical explanation discretely contains the problem within the individual's biology, implies that the individual need no longer attempt to make sense of their experiences of depression and offers the hope of potential resolution. For example Martin, an out-patient interviewed in *Study II*, said:

> 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.

But a psychiatrist interviewed in *Study III* argued that there was an assumption of biological causation in psychiatry, as yet unproven, and that the distinction of depression from other experiences such as unhappiness is based on this assumption. No proven explanation of depression is available, although a biological basis is implied in its definition as an illness. (See also section 3, below).

> 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.

2.2.3 Rejecting medical explanations of depression as individual pathology

The medical discourse of depression as an illness may be rejected as inappropriate in accounting for problematic experiences as part of everyday life and in relation to social situations.

Angie, interviewed as a patient of a general practitioner in *Study II*, resisted the social pressure to explain her depression as post-natal depression (PND) caused by childbirth, and instead believed that depression should be acceptable as a problem in itself. She may also be interpreted as challenging pathological constructions of depression:

> Angie: 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?

Fran, interviewed in *Study IV*, rejected the medical discourse of post-natal depression. She interpreted her experiences of depression as part of life, with reference to major life events and on-going problems, not as individual pathology. She explicitly rejected the notion that childbirth in itself is the cause of depression, and instead argued that depression and childbirth are meaningful within the wider context of the individual's life experiences and social situation.

> Fran: It's not so much, um, I don't think having, like a lot of people say when you have a baby and all this post-natal depression thing, it's like a hormonal thing and you have a baby - I think it's just a load of rubbish. I do think all them things were there before I even had a baby, it's just major events in your life - births, deaths, babies, er, any major thing like that just brings up a lot of different things.
> Siân: Yes.
> Fran: And you feel it then at them times. I don't think you suddenly become depressed because you've had a baby - because if everything was alright before, a baby isn't going to make things be there what weren't there originally, I don't think.

Nicolson (1988) similarly found that women rejected the notion of PND as a description of problems they experienced in the early stages of motherhood, because their experiences were meaningful not as individual pathology but in terms of their daily lives, of the practical problems of early motherhood and the lack of adequate and appropriate support. However, while problems may not be understood as medical and the diagnosis of a medical problem of depression may be rejected, medical help may be the only readily available form of help, although seen as inappropriate (see section 3).

Individuals who do not want to see themselves as unable to cope with their roles, may also avoid identifying depression as the problem. Notions of depression may be especially problematic for women, who see themselves as carers of others, since being depressed would define them as needing rather than as giving care. This may be a particular problem in motherhood, as well as in women's caring relationships throughout the lifespan.

Eric, also an out-patient interviewed in *Study II*, identified his problem as his "nerves" (he suffered uncontrollable shaking and trembling) and rejected the notion that he was depressed. He also believed that medical treatment was inappropriate and offered no hope of resolution, since he saw his "nerves" as caused by family problems at home, but he continued to see his psychiatrist.

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".

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.

2.2.4 Constructing alternative (social) explanations of depression

Individuals may also consider that social problems are part of their experiences of depression. This has implications for how they conceptualise their problems, the action they take, whether or not they see their problems as depression and whether they understand depression as a medical problem. As Gilbert (1992) has suggested:

> "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)

A general practitioner Dr. B., interviewed in *Study III*, suggested that how people interpret their problems has implications for the action they take and for how they experience problems. He drew a link between people's reactions to distress and where

they see the source of their distress. He argued that problems which are attributed to personal and individual causes are experienced as mental or physical symptoms of depression, whereas problems which are also attributed to social causes may lead to action at the level of the community and may or may not be seen as depression:

> Siân: How would you see the concept of depression developing? Would you see it changing?
>
> Dr.B.: I think there are two sorts of concepts, three concepts actually, which would be useful. One is to develop a concept of maladaptive responses or inappropriate responses to situations. The second is a concept of demoralising, that people are demoralised, and I think there's a lot to be demoralised about. There are a lot of people, OK, so it's a question of how people adapt to it. And the third concept, which I think is very important, is where people see the source of their problems coming from, and why that's important is because it's a link between something and political activity. Let me explain that. That we know that people will somatise in the sense that they will focus their distress on physical symptoms at one level. Equally we know that people will feel there's something wrong with them and also view their problems as lying outside themselves which leads to, I don't know that it's political activity with any sort of party label, but they will try to do something about it by going to... getting involved in neighbourhood activities or something like that.

However, the suggestion that the identification of social problems leads to social action presupposes that individuals are free or able to act. Evidence from interviews about subjective experiences of depression *(Studies I , II and IV)* suggests that individuals may to some extent explain their personal problems as social problems. However, this explanation may not empower distressed individuals to act and may increase feelings of powerlessness.

Depression was identified as a common or social problem as well as a personal problem, and explained in terms of socio-structural problems such as unemployment *(Study II)* or the social construction of motherhood *(Study IV)*. These are issues for which one cannot personally be held responsible, but which determine the structure of one's life. But explanations at the socio-structural level may reinforce feelings of powerlessness. They may reinforce perceptions of personal inadequacy to cope with, resolve or move out of depression, since such problems exist at a level beyond the individual. There is no readily available solution to problems which exist at the social level and this reinforces feelings of being trapped in depression.

Individuals may perceive problems to be social at the same time as they experience them as personal and themselves as powerless to deal with social issues. For example Frank, an out-patient interviewed in *Study II*, was unable to find work and saw paid work as the solution to his problems. He believed that unemployment was a cause of his

depression and also recognised that unemployment was a widespread social problem, of which his experience was a part and for which he was not personally responsible. This increased his feelings of powerlessness. Frank explained his depression and anxiety as the result of unemployment and as a common experience.

> 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.

He is unable to find a job and knows that opportunities are limited. At the same time, his doctors construct his depression as a problem which he alone can solve rather than as a biological problem with a medical solution.

> 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".

Chris, an out-patient also interviewed in *Study II*, rejected the diagnosis of depression because he was unable to identify any reason why he might be depressed, but he believed his problems would resolve themselves if he could get work. On the other hand, he felt too ill to work and thus was unable to achieve what he saw as the solution to his problems. While he believed that psychiatric services were inappropriate and ineffective in resolving his depression, he had no alternative or readily available form of help.

> 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.

Ros, interviewed in *Study IV*, recognised that her experiences could be conceptualised as depression, but that they were also common experiences of motherhood. She was positioned between seeing herself as depressed and the recognition that her problems formed part of the reality of motherhood for many women. She suggests that it would be inappropriate to identify her experiences merely in terms of a clinical syndrome contained in the individual, and the recognition that her experiences were common to other mothers enabled her to explain them as part of motherhood.

Ros felt cheated and misled through the social construction of motherhood as a fulfilling experience. She was angry and disappointed, but by herself she was powerless to change this version of motherhood. Her expectations *had* been disappointed. Her recognition that her experiences were socially constructed may have enabled her to avoid blaming herself or seeing herself as inadequate. But this did not necessarily help her to change her situation and may have left her feeling more angry and frustrated. (She was an artist who also expressed herself through powerful images of exploited and angry women).

Ros: I think it's also to do with having a very little baby and not being very supported and being up all those nights. I mean, I suppose there are clinical descriptions of depression of not being able to sleep, waking all through the night, early waking and... You're quite lonely when you -. I think you do sort of like, it's very easy for those two to merge... And the whole sort of ideas are there, certainly for the first child - not having had much contact - not having had much contact and it's quite a shock, you know, a horrible shock to find you've been bombarded with all this wonderful 'Mothercare' image - and it was so much more difficult and exhausting because I hadn't had any kind of contact with children and parenting. Um, so that um, when it was so unglossy -.
Siân: Was it, in a sense, a big disappointment?
Ros: Um -.
Siân: Or how does it make you, kind of, feel about it all?
Ros: Just conned really. Um, but um, yeah. Yes, conned that it was going on and people perpetuating it. Um, and I certainly feel that, I mean, I've had quite a difficult low period recently.

The availability of social explanations for personal experiences of depression may potentially enable individuals to construct a non-pathological account of depression. But this is not a necessary consequence of identifying social factors. Individuals may interpret their experiences as pathology or illness at the same time as they identify socio-structural issues which are incorporated into their experiences. For example Frank, interviewed in *Study II,* said:

Frank: There again, I can't tell you, I just can't - I am frightened to death - if something just snap - and I do it [suicide] like without thinking - that's what I'm afraid of.
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.

Depression may be constructed both as pathology and as caused by social problems. Individuals may draw upon a medical construction of depression as individual

pathology, and at the same time explain depression in terms of their roles and experiences. Jean explained her depression as caused by her multiple and overwhelming roles, and the unreasonable demands made upon her.

Siân: When they originally said "clinical depression" what did that, kind of, mean to you?
Jean: Er, depression which had been brought on by the fact that I was trying to cope with too much.
Siân: Yes.
Jean: Being a wife, being a mother, being a Minister's wife, being a school teacher. You know, the super-woman.

However, she also constructed herself as inadequate in being depressed and depression as a clinical and individualised problem. She saw her husband as coping well with her problems of depression, and herself as the burden he had to cope with, in a pathological construction of herself. (Despite the fact that she had given up her own career in order to support him in an unpaid role as a church minister's wife.)

Jean: You know, I think my husband's done well to stay with me. Erm, 'cos he has suffered from my problem for, like, twenty-nine years - which is a long time.

The recognition of social issues as part of experiences of depression may enable individuals to see their problems as shared and even as socially caused. But this in itself may not empower them to change their situations nor to resolve their problems, although it may empower them to reconstruct their problems as shared rather than individualised and to avoid self-blame to some extent. Depressed persons' beliefs that their problems are at least in part social may reinforce their feelings of powerlessness, as they feel unable to individually resolve social issues. Shared action or shared experience is not readily available, especially when one has become depressed, since part of the problem of depression is feeling cut off from and apart from others (see section 1, above). Depressed persons may identify social problems and causes of depression, and avoid the implications of this by constructing themselves as inadequate in being depressed.

Both men and women may experience themselves as powerless in the face of social problems, although in different ways. As argued in this thesis, both motherhood and unemployment may be experienced as powerlessness. Both unemployment and motherhood may be individualised experiences where usual forms of connection and integration with others, through paid work and leisure activities, are lost. Both unemployment and motherhood bring little social recognition or achievement, and the

qualities needed to cope with both are not commonly recognised. Instead, both the unemployed and full-time mothers are often marginalised as non-achievers.

Some individuals interviewed saw medical services as inappropriate for problems which they did not explain in terms of pathology. The dilemma for them then may be that there is no alternative or appropriate help available. (See section 3, below).

2.3 Reconstructing "depression"

Some individuals may reject the medical discourse of depression as inappropriate, but may be unable to successfully construct an alternative discourse (see section 2.3.4, below). However, other individuals did construct alternative and reflexive accounts of depression as a process of personal change, through retrospective reflection upon their past experiences. In these accounts, depression was explained as a constructive rather than as a pathological experience. Depression was constructed as a meaningful experience of self, as part of the individual's life, rather than as something which happened *to* the individual. It was also constructed as something which has been gone through, which does not last forever and within which the individual does not remain trapped.

2.3.1. The construction of depression as a process of change, a complex and variable experience of self

Depression can be understood as a complex and variable experience of self, and the experience of depression as one aspect of a multi-dimensional and dynamic self.

Depression may be conceptualised as part of the person's on-going experience of self. (See Chapter One, Parts II and III, for discussion of the neglect of the person in mainstream psychological approaches to depression). Depression may be explained as dynamic and variable experiences rather than as a static category. Following social behaviourism (Mead, 1934), social experiences are both incorporated into the self and constantly reinterpreted in a dynamic process of reflecting upon subjective experiences and re-experiencing and re-constructing the self. Drawing on Giddens' (1979) concept of durée (see Chapter Three, Part II, section 2.2), accounts of subjective experiences of depression can be seen as the product of biographical experience, of life history and of the individual's current social standpoint or position.

For example Ros, in *Study IV*, described depression as a layer of her experience and as incorporating what she had experienced in the past and what she is currently experiencing. She explained depression in relation to past and present experiences. She portrays herself as actively reflecting upon her past experiences and attempting to make

sense of them and of her current emotional problems, through an on-going inner dialogue.

Ros also explained depression as a process of adaptation, itself problematic. She explained her experiences of depression in terms of changes she was making in her life, in herself, and in her experiences as a parent which contrasted with her own experiences before she had children and in being parented as a child herself.

Ros: Um, well I have a little difficulty with the word depression.
Siân: Oh yes, what do you think it means or - ?
Ros: Yeah, um, well, sort of, I think yeah I do get depressed, but I think it's kind of like a layer in my experience because I can feel happiness at times but I've got this, like, layer of undealt with stuff... I suppose I could say I feel quite happy and depressed at the same time. And it depends on how it's working out and where it comes through... Um, and I suppose I look at particular things like I feel I try, I know I've been really heavy with myself and try and let go and give myself an easy time of not being self critical and - think, "Oh yes, I'd probably be better if I just laugh, I'll probably feel better in a week," and just let things go a bit more. But I've got this ongoing dialogue about it. Um, um, but I do sort of feel the stuff that comes up in home life can really sort of trigger stuff, and it really looks bad. I can get involved in quite big rows and lead to really low, bad feelings spewing out that I didn't know were there. I think I'm going to sneeze. Er, and just, the change of it, you know, and I do feel, because I'm really trying to live differently, um, um, I'm trying to break away from my parents and be a different kind of a parent, and really trying to change particular aspects of um, just, I suppose I didn't realise how difficult it is.

Depression may be retrospectively interpreted as an opportunity to effect personal change. Ros's construction of depression as a reflective experience, incorporating past and present experiences of self, is similar to Fran's construction of depression as an opportunity for self-learning, through self-reflection and the reconstruction of past experiences, in the following two excerpts. (See also section 1.1.2 and section 1.4, above).

Fran: I do think you can learn a lot about yourself through your depression. A lot about yourself, and at the end of the day you can have a lot more confidence than you ever dreamed that you would have before. If you can manage to get through it.

Fran: The only way I can talk about things really is from having come through a lot of things.
Siân: Yes.
Fran: That I feel I can understand things more, and I think it's like, um, it sounds a bit corny but I think it is like, if people have gone through things, if you come out the other end, if you do feel positive about things eventually, it really is more like a gift than -
Siân: Ahhh it doesn't sound corny -

Fran: It can be, you know, because you can learn so much more about yourself after you've gone really in -
Siân: Yes
Fran: - and then found the strength to come out the other end, you know? So I think, um, that I can look back on my life now and see times when I was actually depressed but never acknowledged it.

Fran, through reflecting upon her past experiences, explained depression as a process of change and as an opportunity for self-development. She constructed depression as a dynamic experience of self and as a meaningful experience of self-development. It may be because she has changed, and through contrasting her past self with her present experiences, that she is able to say that she was depressed in the past. Part of her definition of depression may also be that depression is a past experience.

John, interviewed in *Study II*, saw coping with depression as a process of becoming aware of patterns in past and present behaviours and experiences. He accounted for depression as an opportunity for personal growth and development and considered that depression indicated a need for personal change.

John: 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.

Part of his experience of depression had been turning away and withdrawal from relationships and social interaction. This is consistent with the sense of difference and apartness identified as part of the experience of depression (see section 1, above). He suggests that part of the process of coping with or moving out of depression is to become aware of and resolve problems which have been avoided through withdrawal. Part of recovery from depression may be to again become involved in relationships with others (see section 1.4 above), though in more positive relationships, and not necessarily with the same people with whom relationships were problematic in the past.

2.4 Summary: interpreting "depression"

Mead (1934) argued that individuals actively reflect on their experiences in a dynamic process. The self is not a stable construct but a process, constantly developing as the individual reflects on their experiences. The individual is active in reflecting upon and reconstructing their social world. (See Chapter Three, Part II, section 3).

Following a symbolic interactionist perspective, subjective meanings of experiences of depression are conceptualised as dynamic and changing, evolving through new experiences, over time and through relationships with others (Mead, 1934; Blumer, 1969). Individuals' constructions of meaning both incorporate and reinforce powerful social discourses and values. The construction of meaning is the result of the individual's reflection on their experiences and their interpretation of shared social and cultural values.

Individuals are seen to reproduce, reconstruct and reject the powerful medical discourse by which depression is constructed as individual pathology, in their accounts of experiences of depression. Individuals may show ambivalence as to whether they describe themselves as depressed. The term depression was used within different contexts and with variable meanings throughout interviews, as individuals reflected upon and reconstructed their experiences. For example Chris, an out-patient interviewed in *Study II*, reinterpreted his experiences as depression during the course of the interview, having initially rejected the notion that he was depressed. Experiences are open to reconstruction and reflection.

Individuals may wish to identify their experiences as a distinct problem of depression and may also wish to avoid the pathological and clinical connotations of the term "depression". They may identify their experiences as depression but at the same time reject the pathologisation implicit in the term "depression", which has clinical connotations. This leaves them in a dilemma. There is no available term other than "depression" with which to identify a distinct problem, since the terms "feeling down" or "low" convey emotions but not a distinct problem. Use of the term "depression" to identify a distinct problem carries connotations of the clinical discourse. For example Ros (*Study IV*), who identified herself as experiencing depression, said that she found the term problematic and she attempted to redefine it in terms of her personal experience.

The meaning of the term "depression" is variable, and the ways in which individuals interpret their experiences as depression, or not depression, are potentially contradictory. A clinical discourse is implied simply in identifying a problem as

depression and the notion that there is an entity called depression is reinforced. Depression itself becomes the problem.

Individuals both use and reject the term "depression" in describing their experiences, in validating problems and in rejecting the pathological implications of the term "depression". It may be that it is easier to identify depression as a past experience, since it is through the process of reflexivity, or reflection on past experience of self, that the "I" becomes an object to itself as the "me" (Mead, 1934; see Chapter Three, Part II, section 3). If depression is a changed experience of self, then distance and intermittent experience of oneself as not depressed may be needed to recognise the change. It may also be easier to identify past experiences of depression since these may be more easily explained. For example, Penny (*Study IV*) was able to both explain and identify her past experiences as depression, Chris (*Study II*) identified himself as having been depressed, and Margaret (also *Study IV*) was able to recognise depression on the basis of past experience. It may be that the label of "depression" is more easily applied to past experiences. This also provides another example of commonality in accounts of experiences of depression between men and women.

Identifying depression as the problem was not a sufficient explanation of a person's experiences. Individuals attempted to make sense of their experiences and to explain why they had become depressed. Individuals sought to explain the problem of depression in terms of their lives and experiences, and did not confine their explanations to assumptions of individual pathology. For example, Chris, Frank and Douglas (*Study II*) identified unemployment or lack of work (Douglas had retired) as a problem, and employment (or more activity) as a solution to their depression. Chris and Douglas did not necessarily explicitly identify unemployment as the *cause* of depression, although Frank did, but they did make sense of their experiences within the context of their lives and social circumstances. Ros (*Study IV*) explained depression as a process of adaptation and personal change, as part of her experiences of motherhood and as incorporating her disappointed expectations of motherhood. Cate (*Study IV*) similarly explained her experiences in terms of personal change and adaptation. Individuals do attempt to make sense of their experiences of depression as part of their lives.

Depression may be an experience of oneself as *"other"*, as abnormal and unacceptable. In alternative constructions, depression is both explained and given meaning through reflection on subjective experience. Individuals explained depression as a meaningful and potentially constructive experience of *self*. For example, John (*Study II*) and Fran (*Study IV*) saw depression as indicating a need for and providing an opportunity for

personal change, if used constructively. Ros (*Study IV)* and Cate (*Study IV*) explained depression in terms of changes they were making in their lives and selves. In constructing this version of depression, individuals rejected the discourse of depression as pathology and as an experience of other and developed an alternative construction of depression as a meaningful experience of self. However, this version of depression was usually constructed in reflecting on depression as a past experience.

Individuals who accepted a clinical diagnosis of depression were not, however, necessarily enabled to explain their experiences of depression. The diagnosis might carry an assumption of biological causation. Although the assumption of biochemical causation was not supported (for example, in interviews with clinicians, see Study III, Chapter 6, and in this chapter sections 2.2.2, above, and section 3.1, below), this assumption might be taken up as a powerful explanation, given the mystery of depression.

Part of the problem of the diagnosis of depression was that it did not help individuals to make sense of their experiences (Lewis, 1995). It was powerful in defining a person's experiences as a clinical problem and the person as ill but not in explaining, making sense of or resolving their experiences. This left individuals in a real dilemma, attempting to make sense of their experiences as part of their lives, while these were also defined as pathology, as mysterious and as the province of medical experts who, however, had offered them no explanation.

Individuals do attempt to make sense of their experiences both as the specific problem of depression and as part of their lives, but depression itself, once identified as the problem, remains a mystery. Once depression is identified as a problem, with implications of a clinical entity, the focus of explanation is shifted away from the meanings of individuals' lives and experiences, as depression itself becomes the problem to be explained and yet remains inexplicable.

One implication of this is that it might be useful for clinicians to ask patients what the term "depression" means to them, and how they have coped with being diagnosed as depressed (Lewis, 1995). It is clear that the term "depression" has powerful implications for the ways in which individuals interpret their subjective experiences and for the construction of self. While receiving a diagnosis of depression may be experienced as liberating and a relief (Karp, 1994; see also Chapter Five (Study II), and section 2.1.4 above), the diagnosis is also seen as pathologising and stigmatising. For example, Chris (*Study II*) had difficulty telling his wife that he was depressed (see section 2.1.2 above). It may be important for health professionals to investigate the

meaning of the diagnosis for patients and their families and carers. A diagnosis of depression is not neutral and may have implications for how a person feels about themselves, and how other people view them.

Individuals may find the term depression antagonistic to their constructions of self. This may be explained in relation to constructions of gender identity. Alternatively, a person may experience depression as a loss of self (Oatley and Bolton, 1985) or a failed self, as they fail to fulfil social constructions of identity. The implications of the term "depression" may differ between men and women and may affect health behaviour, and may determine whether individuals identify their problems a depression, and if and when individuals seek help with depression.

More women than men have been interviewed in the research presented in this thesis, and more can be said about women's experiences and interpretations of depression. But there are indications from interviews with male patients (*Study II*) that the diagnosis of depression is problematic given constructions of male gender identity: Chris (*Study II*) said that depression was something which happened to others and Eric (*Study II*) rejected the idea of depression. The identification of a problem of depression also has implications, for example, for the construction of women as "copers" and carers with no needs of their own. Cate felt that she could not afford to describe or think of herself as depressed, because she would then be unable to cope in caring for her family. Ros felt that she had no right to ask for help because she was a "coper".

The term "depression" might have different meanings as an interpretation of female as opposed to male experience. The research presented in this thesis suggests that women may accept depression as an inevitable part of their lives as women, while for men depression may be seen as an aberration from the norm. Women who accept depression as part of their lives may have fewer expectations of resolution, and may be less willing or less hopeful in seeking help, and may see medical help as less appropriate for problems which they do not regard as pathological (see section 3, below). Men, on the other hand, who see depression as an aberration from the norm, may seek medical help more as a source of resolution, rather than as a last resort, and may be more inclined to see their problems as pathological, (although the diagnosis of depression may still not help them to make sense of their experiences, to explain their problems or to resolve them).

While the research for this thesis cannot indicate conclusive results, it does suggest that men and women may differ in what they experience as depression, how they make sense of their experiences, and whether or not they interpret their experiences as

depression. Building on what has been achieved here, the meaning of the diagnosis can be identified as an important area for future research, looking at meanings for men and women, and for both patients and health professionals giving and using that diagnosis. This has implications for targeting health promotion and for public education about the problem of depression.

3. THE CONSTRUCTION OF DEPRESSION AS A MEDICAL PROBLEM

What help is available for individuals who become depressed? This section discusses how the availability of help for depression and the process of help-seeking through the health service, is incorporated into interpretations of experiences of depression and constructions of experiences as depression. It is argued that depression is constructed as a medical problem through social processes and actions.

3.1. Treatment discourses

The problem of depression may be defined through available treatments. In the absence of a prior definition of the problem of depression, on which treatment might be based and the efficacy of treatment judged, depression may be defined in terms of the treatment available.

The medical discourse of depression is reproduced and reinforced through the availability of drug treatment, given that only doctors can prescribe drugs. Dr.B., a G.P. interviewed in *Study III*, argued that the problem of depression has been redefined through the availability of psychotropic drugs. With the power to treat depression comes the power to define depression. The availability of medication for depression gives doctors the power to define depression and reinforces the definition of depression as a medical problem.

> 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.

The efficacy of medication in reducing symptoms may feed back into definitions of depression as a medical problem:

> 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.

Depression becomes a problem which can be effectively treated by doctors through medication, where efficacy of treatment is defined within the medical model in terms of symptom reduction. The definition of depression as a biological problem, in the face of competing alternative explanations, for example as a social or psychological problem, may be the result of the ready availability of medication. In a pragmatic approach, the doctor may give the treatment which is most easily available and fastest working, rather than attempting to resolve underlying problems. For example Dr. T., a G.P. interviewed in *Study III*, used medication as a stop-gap for symptoms of depression, although he considered these symptoms as the manifestation of problems which might be socially or psychologically caused.

> 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.

Depression cannot be clearly defined, in terms of whether someone clearly has depression or not. In a pragmatic approach, it is defined in terms of appropriate treatment and availability of help.

> Siân: So should it [depression] 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.

The question of when depression becomes a clinical problem, a form of pathology for which people need medical help, may be answered in terms of available treatment. The availability of treatment determines when depression is defined as pathological and by implication as a real problem. Pathology is defined not in terms of a norm of health, but in terms of the efficacy and availability of treatment, measured in terms of symptom reduction. The question of when depression is a problem becomes a question of how

depression can be treated, based on the assumption that all depression is pathological or potentially pathological.

> 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.

The availability of treatment may be an organisational issue, not a scientific issue. The availability of treatment may be determined by organisational measures of efficiency, rather than through research, practice or experience. Thus, where the problem of depression is defined through the availability of treatment, the questions of when depression becomes a problem, the nature of that problem and who is responsible for resolving the problem of depression, may be answered in terms of organisational goals and values.

This may be increasingly so, given increasing emphasis on efficiency, costs and accountability within the health service. Interviews with clinical psychologists (*Study III*) suggested that the medical model is increasingly dominant within the health service and that it forms the basis of treatment approaches and of accountability in practice. There is little room for alternative approaches to depression. Through increasing emphasis on medical models of treatment within the health service, depression may increasingly be defined as a medical problem.

For example Rob, a clinical psychologist interviewed in *Study III*, argued that treatment for depression would be increasingly determined within the medical model. He considered that the medical model of depression as a disease was increasingly powerful, with fewer alternative options for patients.

> Rob: I think the predominant, if you're a sufferer from a depressed experience and you present for services, your 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 there are lots of them around. Don't worry you'll feel better. And don't forget it'll go in six months time anyway.

Definitions of depression in terms of treatment availability may reflect the values of health service organisations. The question of when depression becomes a problem and for whom, may be answered as: when symptoms (defined according to the medical

model) are shown for which effective medication is readily and cheaply available. Depression is not necessarily defined in terms of patients' experiences, and questions of when depression becomes a problem for the patients, what it means to them and the nature of that problem, may be ignored once they enter the medical system.

Problems may be defined in terms of professional expertise, but it is not clear that the skills offered are necessarily appropriate to the problems experienced. Who is to decide on appropriate treatments if the problem of depression has not been clearly defined in the first place, and in particular if it is defined in terms of available treatments? The implication that depression is a medical problem may both reflect and reinforce the power of medical professionals in the health service.

3.2 The construction of depression as an illness

Who defines depression as an illness? Is depression necessarily an illness because people experience it as an illness? Is depression an illness only when doctors define it as an illness? Is an illness necessarily a medical problem and to be treated in the medical system?

Dr. P., a psychiatrist interviewed in *Study III*, argued against a biological model of depression. He claimed that since *patients* visited doctors when depressed, *they* experienced depression as an illness, and so depression should be treated as a medical problem and, at least initially, by doctors. His definition of depression as a medical problem is based on patients' actions in seeking help through the medical system.

> Dr.P.: 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.

Conversely, depression was defined as an illness by doctors in terms of their medical specialities and professional expertise. For example Dr. D., a psychiatrist interviewed in *Study III*, argued that she only treated psychiatric illnesses and that as a psychiatrist she could only treat depression when it met criteria for psychiatric illness. She was not interested in treating depression but only in treating psychiatric illnesses. The criteria for psychiatric illness are defined by psychiatrists in terms of professional expertise and professional needs (see Chapter One, Part I). In these terms then, depression is defined as a psychiatric problem or illness in terms of professional criteria and not in terms of what is experienced by the person as problematic. This limits the scope of psychiatry

and the extent to which psychiatrists can claim expertise in the treatment of depression, but also gives psychiatrists the power to limit what they treat to what they define as a problem in the first place. Definitions of depression as a problem may be based on professional boundaries and domains of expertise rather than on the nature of the problem itself.

Dr. D: 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.

Definitions of problems as depression may inevitably carry clinical/ medical connotations. Dr. G., a G.P. interviewed in *Study III*, argued that depression was better treated by those in the community and that the G.P.'s job was to divert patients to those better skilled than doctors. (Similarly, Dr. T., another G.P. interviewed in *Study III*, saw his role as to divert at least some patients to appropriate non-medical treatment, see section 3.1 above). Dr. G. argued that a problem in defining depression was that any definition brought the problem into the realm of medicine, which she did not think appropriate. She believed that doctors only have appropriate expertise to treat physical symptoms and no expertise to treat the problem of depression as a whole. However, it is not clear what alternative expertise is available or appropriate.

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'.

Depression may be defined as an illness according to patients' application to doctors, where the expertise of doctors is seen as covering what patients bring into their surgery. Alternatively, psychiatrists, and possibly other specialities, may use professional definitions of illness to limit the extent to which depression is regarded as a clinical problem, redefining depression in terms of their speciality and limiting their professional expertise to what they define as a problem. However, doctors themselves may not regard medical help as appropriate and may defend their patients' problems

against inappropriate medicalisation while pragmatically striving to give the best help possible.

Interviews showed evidence of attempts to explore alternative models of depression. For example Dr. P., a psychiatrist interviewed in *Study III*, wished to develop a non-biological model of depression. He defined illness as what the patient experiences as illness. But in practice, doctors rather than patients tend to define illness, and their definitions reflect their professional speciality and territory and not necessarily patients' experiences. However, a pragmatic approach may be useful in focusing on the patients' experiences and needs, rather than on specialised expert knowledge which defines depression according to available treatments.

One issue in whether and how depression is constructed as a medical problem and experienced as an illness, is what help is available when people feel depressed. The definition of depression as a medical problem may be implicit in the term "depression" because medical help is often the *only* help readily available, and this implication may in turn reinforce the role of the doctors in providing, at the very least, initial screening and treatment for depression.

3.3 Help seeking for depression: the availability of medical help

There is little readily available help for individuals experiencing depression. It may be that the most readily available form of help is through the G.P. People experiencing depression as a problem for which they need help may therefore turn to their G.P., although they have not thought of themselves as ill or as suffering from depression.

Individuals may look for medical help in desperation, as the *only* form of help available and not because they experience their problems as illness. For example Cate, interviewed in *Study IV*, explained that she had not thought of herself as depressed until her G.P. suggested it (only for her G.P. to deny that she was), and that she had gone to her G.P. as a last resort, because she needed support and not because she saw herself as ill.

> Cate: I sort of told him that I was feeling really down and I couldn't cope and everything and he just sort of said to me, "Well, do you think you're depressed?" and I was like, "Well, yea, I do," and he's like, "Well, I don't think you are," and, "Just kind of get on with it," you know, "Things'll get better". "If you still feel like this in a month then come back," you know. So I like went back again about it, but he just said the same thing. He just made me feel like. He said to me, "Is it drugs you want?" and I was like, "No, no, I've had a drug problem and I've got a two year old child, I'm not going to start taking drugs again". Well, that's the way I

felt, that he was looking at me as like, you know, a sort of junkie and I was just like trying it on to see what I could get.

Siân: You know like when he said, "Do you think you're depressed?" had you thought about it as being depression before he said that?

Cate: Well, no, no, I think, I wouldn't have consciously sat there and said, "Oh, I'm depressed". I thought about everything getting on top of me and how I couldn't cope and I needed some help, you know, but I wasn't. I don't know what I wanted. I just wanted someone to help me, you know. I needed somebody just to talk to me and tell me that things weren't as bad as I'd seen them, kind of thing, but no, he didn't give me any help. I suppose I came out feeling worse.

Conversely, receiving help for depression may be conditional upon being clinically diagnosed as depressed. Cate's G.P. asks her if she is depressed and then tells her that she is not, implicitly denying that she has any real problems. He offers her no help (a return visit produces no solution). She is left believing that she is seen as a fraud, having been denied her G.P.'s help, although she did not go seeking medication, and she has nowhere else to go.

Individuals may turn to medical authorities for help because that it is the only form of help available, although they do not necessarily see it as appropriate. Receiving a diagnosis of depression may be a necessary condition for receiving medical help, but this does not necessarily mean that medical services are appropriate.

For example, Ros (*Study IV*) considered medical approaches as inappropriate. She believed that problems were defined according to the constraints of the medical system rather than in terms of patients' needs and experiences. She considered that the categorisation of problems as medical problems determined the help or treatment available but failed to address the problems patients actually did experience. Inappropriate treatment was offered, on the basis of medical categorisations of problems and the demands of the medical system, rather than in terms of the actual problems people were experiencing. The patient or person was forgotten, as the focus shifted to the medically diagnosed problem.

R Once I'd said I was going to commit suicide next week it was all kind of like, "This is the problem, let's do something about it".

S Was it said like that?

R She did actually say, "This is a problem"... so um, but of course I did feel that they wanted it all to fit into neat corners like, "You can go there, you can get the C.P.N., our counsellor," and, you know, but they can't look at you in, see it in a different way or - .

S Did they seem to take it seriously though?

R Well how can they take it seriously if they don't do any follow up. I mean, OK, they all appeared to, but, I mean, I think they just wanted to make sure they didn't have a suicide on their list... They just like you to take something so they can feel they've done something and alleviate

> their conscience. Or come back and have loads of psychosomatic illness so they can feel they're doing something.

While the health care system encompasses a variety of disciplines, it may offer treatment on the basis of problems defined according to dominant organisational (medical) values and fail to adequately take a person's actual experiences and needs into account. Distressed individuals may continue to turn to doctors, not necessarily because doctors offer appropriate help nor because patients see their problems as medical, but because their G.P. may be the only readily accessible form of help. (As suggested in sections 3.1 and 3.2, above, and in Chapter Six, G.P.'s act as gatekeepers to care but this implies that the depression is, at least potentially, a medical problem in the first place.)

The questions of who defines depression, when depression becomes a problem, what the problem is and for whom it is a problem, may therefore be answered in suggesting that in practice depression is medically defined through the availability of medical treatment and through the structure of medical services in gatekeeping the available treatments. But a medically based approach may fail to ask what the distressed person themself experiences as problematic and what help the person wants, and side-steps the issue of the appropriateness of treatment.

3.4 Summary

A strong theme in interviews with clinicians (*Study III*, Chapter Six) was the definition of depression through treatment discourses which emphasised the availability of treatment. Depression which can be treated is a clinical problem. Depression then is defined as a problem according to professional expertise and ability to deliver treatment. Conversely, the availability of treatment through medical services, and particularly through G.P.'s, may define depression as a medical problem for depressed persons, since there are few alternative sources of help.

A treatment based definition may enable a pragmatic approach, particularly evident in interviews with G.P.'s, whereby depression is seen as a multi-dimensional problem, and treatment is geared to achieving the best possible solution within the constraints of the health and social system and given the particular patient's problems and social situation. But some clinicians such as Dr. D., a psychiatrist interviewed in *Study III,* may redefine depression in terms of their speciality, as a psychiatric illness, and treat problems which they regard only as psychiatric illness (see 3.2, above). While recognising that she is unable to change individuals' social conditions, Dr. D. also suggests that when depression is diagnosed as a psychiatric illness it is treated in isolation from the person's social position or situation.

The structure of access to help through G.P.'s may define depression as a medical problem in any case, on the basis that it is treated through the medical system, even though the G.P.'s role may to act as gatekeeper to other non-medical forms of help (see Dr. T., section 3.1, above).

The ways in which individuals experience and interpret their problems are influenced by clinical diagnoses, as argued in section 2, above (and in *Study II*, Chapter Five). For example, patients may regard themselves as depressed because their doctor has diagnosed them as depressed, and they may identify their problems as depression through the diagnosis. Doctors may have ownership over depression or the power to define depression; individuals may also have difficulty in saying that they are depressed when their doctor has refused to diagnose them as depressed, for example Cate (*Study III*), see section 3.3, above.

The powerful medical discourse of depression as an illness may be reflected in and reproduced by processes of help seeking and treatment through the health service. Giddens' (1979) theory of structuration reconceptualises the notions of social structure and the individual in terms of the person's actions as within, incorporating and reinforcing social process (see Chapter Three, Part II, section 6.1). Discourses can be seen as actions through which individuals both incorporate social processes into subjectivity and reinforce those processes. Thus a medical discourse of depression as pathology is incorporated into self-identity as depressed, is reinforced and reproduced by the use of "depression" as a diagnostic term, and is reproduced in the acts of applying for, giving and receiving treatments through the health service.

Discourses and themes identified in health professionals' accounts of depression suggest that a consideration of discourses alone is not enough, and that discourses should be considered as the product of organisational processes. The use of a clinical discourse of depression both reproduces and reinforces the idea that depressed people need medical help. Treatment of depression within the medical system also reproduces and reinforces the construction of depression as a problem of individual pathology.

Medical help may be the only form of help available to depressed persons, and they may be placed in a contradictory position of seeking medical help while they do not regard their problems as illness or medical treatment as appropriate or even helpful (see section 3.3, above). Individuals may seek medical help at the same time as they avoid the term "depression", as a clinical term which is not relevant to their experiences (see for example Cate, section 3.3 above, Ros, section 2.3.1,. above and Chris, sections 2.1.5

and 2.2.1 above). They may continue to appear for treatment at the same time as they have little hope of resolution through treatment, because that is the only help available. But this may in fact compound their problems and experiences: for example, Cate, *Study III,* (section 3.3, above) felt devalued as a result of her consultation with her G.P.; and Ros (section 3.3, above) felt angry and that health services had failed her and yet had few other places to turn to.

3.5 Issues for future research

3.5.1 Defining depression: The organisation and values of health care

Analysis of patients' experiences within the health system, and of their contradictory positions, has implications for targeting health promotion and also for understanding patient non-compliance with treatment. Individuals may seek help and consult with their G.P.'s and yet not follow treatment regimes because they do not regard them as appropriate, given their own understandings of their problems. Patients' experiences in the health service may themselves be problematic and compound the problems they are already experiencing. As argued in section 2.4, above, clinicians may need to investigate the meaning of the diagnosis for their patients but they also may need to take into consideration the treatment their patients consider appropriate. However, and at another level, to do so may be problematic for clinicians because it may conflict with the values and goals of health service organisations. It has been argued in section 3, above, that the problem of depression and the availability of treatment for depression may be defined in terms of health service organisations' goals and values, rather than in terms of individuals' actual experiences of depression. This issue is unresolved here and an area for future research.

Health professionals appear to be unable to agree on a definition of depression (see *Study III*, Chapter Six). They define depression with reference to treatment. Biological causation is assumed and may be incorporated into the clinical discourse (see sections 2.2.2 and 2.2.3, above). What does appear to be powerful in defining depression is the medical system, which defines it as a medical problem in terms of medical specialities. This research has indicated that depression may be defined as a problem through the power of clinical discourses, and that definitions of depression may reflect the power of medical professions within health service organisations. Developing this, a question for future research may be: How far is the definition of depression as a general medical, psychiatric or psychological problem based upon professional expertise in dealing with problems patients actually do experience, and how far upon professional identity, speciality and even market share within the health service? The definition of depression as a general medical, psychiatric or psychological problem may reflect the power of different professions and medical specialities within the health service.

For example, there is some indication of competition between medical specialities in terms of their perceived expertise in treating depression. Dr. G., a G.P. interviewed in *Study III*, said that she would avoid sending a patient to a psychiatrist because psychiatrists had no particular expertise appropriate to the treatment of depression which was additional to the expertise of G.P.'s. She regarded psychiatrists' skills as those of control and management, but not resolution. (Yet psychiatrists interviewed in *Study III* were convinced of their specialist expertise, though they had different ideas of what that expertise was).

Dr.G.: I almost never refer anyone to a psychiatrist.
Siân: Oh, why not?
Dr.G.: Well, I don't think they do much different from what we can do. I mean, what are they going to do? The only people I'd refer to a psychiatrist are those people who are completely psycho-motor retarded. Who are, you know, who have stopped eating or who are actively suicidal - who are at risk. And then I'd have them admitted, but I wouldn't refer somebody with depression to a psychiatrist. Unless they wanted to be.

3.5.2 Public understanding of depression as a health issue.

How far does the availability of help for depression through the health service, and the implicit definition of depression as an illness, affect public attitudes to depression? It has been argued that individuals may avoid seeking help for depression because they feel that there is no appropriate help available, and because they are reluctant to see themselves as depressed. As argued in section 2, above, the diagnosis has meaning and it may compound an individual's problems. An issue for further research may be public perceptions of depression, how depression is understood and whether it is understood as mental illness, and the implications for individuals' social relationships of saying that they have been diagnosed as depressed. This research has been piloted in Study I, using a university based population, and could be extended using samples from other and more diverse populations.

The sense of stigmatisation that depressed people feel may be reinforced by others, when they are pathologised through the notion of depression as a mental illness. The mentally ill are not respected but devalued. This was commented upon by Mary, in *Study I*:

Mary: I know it's not my fault, I know I'm not to blame, but other people sort of do blame me for depression because they just see it as a... a weakness of character...
There's things that they [physically ill] can't do or if they get in a state connected with their illness, you know, there's, er -
Siân: Mm.

Mary: - things you should and shouldn't do or it's just there you know, um, and I just wish people could see, um, mental illness in... obviously it's not the same kind of illness but on the same kind of, um, with the same kind of respect really
Siân: Yeah, because do you think they actually see it differently to how they see physical illness?
Mary: Yeah.
Siân: Like in ,er, what sort of way?
Mary: Um, well I think anything in your head, um, they... you know, it's like you're only imagining it, or if something's in your mind, because it's not like, tangible, it's not like having, you know, stitches in your arm or something, um, it's somehow, sort of, doesn't exist... You know, and you can like blot it out or something or pretend it's not there.

Similarly Douglas, an out-patient interviewed in *Study II*, saw mental illness as pathologising and believed that the way in which other people interpreted his problems as mental illness was an additional cause of anxiety:

Doug: 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.

Common understandings of depression have implications for the experiences of individuals who are depressed, for their relationships and their attempts to explain their experiences of depression. Common understandings of depression may contribute to difficulties in talking about depression and may be incorporated into the experience of depression as an experience of isolation and apartness, as suggested in section 1, above.

PART III SUMMARY

Data from all four studies in the thesis have been drawn together here to look at what is subjectively experienced as depression; whether experiences are interpreted as depression, and the implications of identifying an experience as depression; and how the construction of depression as a medical problem may be reproduced through processes of treating depression within the health service. The discussion has indicated that subjective interpretations of experiences as depression reflect social and structural issues in the identification of a medical problem of depression, chiefly the power of medicine and the fact that the most easily available form of help is through the health service. Depression may be defined as a problem when it can be treated medically and other experiences may be defined as non-medical problems, and therefore not treated as serious nor as "real" problems. This leaves people with few alternative forms of help when they do not think they are ill or when they are not defined as depressed within the limits of the medical model. It also means that in describing themselves as depressed

individuals may inevitably be invoking an interpretation of depression as a clinical problem.

A problem in carrying out the research presented in this thesis has been that the term depression inevitably carries clinical connotations with it, and in using the term, which was unavoidable in conducting this research on subjective experiences of depression, it is difficult to avoid the implication of a clinical state. This problem has been explored through the process of this research, in interviewing and in the analysis of interview data. Interviews have suggested that it is difficult to talk about experiences as depression without reference to a clinical discourse, whether in accepting or rejecting that discourse.

While experiences of depression may incorporate social interactions and relationships with others, as seen in analysis of accounts of experiences of depression, (section 1, above), the meanings of such experiences are both determined by and constructed through the use of the term "depression", which carries clinical implications. To identify experiences as depression is problematic, where the term "depression" implies an experience contained within the individual, and where experiences of depression may be accounted for in terms of a person's social experiences.

The implications of the issues drawn together in this chapter and the research presented throughout the thesis, for the psychology of depression, are discussed in the next chapter. Implications for alternative theoretical and methodological approaches to investigating and explaining the experience of depression are also discussed. Based on the work presented in this chapter, it is argued that achieving greater understanding of depression is not simply a question of explaining individual experiences or interpretations, but includes looking at the social construction of experiences and their meanings.

CHAPTER TEN
THE SOCIAL CONSTRUCTION OF DEPRESSION: DISCUSSION AND CONCLUDING POINTS

INTRODUCTION

Chapter Nine drew together the results of the four studies in this thesis. Themes identified throughout the four research studies, and the empirical and theoretical contributions of the research to the psychology of depression, were developed. Mead's (1934) theory of social *behaviourism* was drawn upon in developing the analysis of subjective experiences of depression and of the social construction of experiences of depression

In this chapter, the research presented in this thesis is summarised, emphasising the theoretical and methodological contributions of the research. Part I of the chapter provides a brief overview of the studies, and of the contribution of the research to the psychology of depression. In Part II, the contribution of the thesis to developing a social psychological approach to depression is discussed and the research is related to previous research on depression which was formative in the development of a social psychological approach (see Chapter One). In Part III, the methodology used in the thesis is summarised and its implications discussed. The research process is also discussed, both as a learning experience and as a practical process of conducting research (see also Appendix B, for further practical details about the research methodology). Finally in Part IV, the contribution of the research is summarised. Throughout this chapter, unresolved issues are identified and areas for future research are indicated (and some have also been discussed in Chapter Nine, section 3).

PART I A BRIEF OVERVIEW OF THE THESIS

Four studies have been presented in this thesis:

Study I, (N=36) an initial study which explored how people talk about depression, and where discourses and themes in accounts were identified (see Chapter Two).

Study II, (N=9) based on accounts of experiences of depression by psychiatric out-patients (N=6) and patients of general practitioners (N=3). These were discussed with particular reference to the power of the medical discourse in defining, validating and legitimating problems as depression (see Chapter Five).

Study III, (N=26) in which accounts of health professionals', as a possible source of the medical discourses used by patients, were discussed, focusing on their approaches to depression and their explanations of depression (see Chapter Six).

Study IV, (N=18) based on interviews with women who were mothers, about their experiences and explanations of depression (see Chapter Eight).

Developing the discussion in Chapter Nine where data from all the studies was related, the research presented in this thesis is summarised and discussed in this chapter in terms of the contributions made to the social psychology of depression. These contributions have been made through:

1. **Explaining depression as a subjective experience**, which is constructed and has meaning through processes of social interaction and in relationships with others. This was achieved through:

    1.1 The identification of themes in accounts of subjective experiences of depression.

    1.2 The identification of discourses used in constructing accounts of depression.

    1.3 The theorisation of depression as a reflexive and interactive process.

2. **Investigating the meaning of the concept of depression, as a description of experience and as a socially constructed reality** (Berger and Luckmann, 1966; Charmaz, 1990). This achieved through:

    2.1 The identification of discourses used by individuals in their accounts of their experiences as depression.

2.2 Investigating how the meaning of "depression" is constructed using available discourses, and the implications of discourses used for communicating about experiences of depression and interpreting experiences as depression.
2.3 Recognising that investigation of the social construction of "depression" may include a consideration of social and structural issues. More specifically, it may include a consideration of organisational processes in the treatment of depression (developing the arguments proposed in the discussion of the interviews with clinicians, see Chapter Six). Although mainly outside the scope of this thesis, this has implications for help-seeking and help-giving, and for the delivery and receipt of treatment (see Chapter Nine, Part II, section 3.).

3. **The theorisation of depression based on symbolic interactionism.** The thesis has sought to demonstrate the value of symbolic interactionism (Mead, 1934; Blumer, 1969), in explaining depression as a reflexive and socially constructed experience. A theorisation of depression based on symbolic interactionism has been developed through a series of empirical studies, based on accounts of subjective experiences of depression (Studies I, II and IV) and of explanations of the problem of depression (Studies I, II, III and IV).

In Chapter Nine, common themes identified in the data across all studies were discussed and the theoretical basis of the thesis was developed, drawing upon symbolic interactionism (Mead, 1934; Blumer, 1969).

4. **The development of a methodology to explore subjective accounts.**
A contribution has been made, through the innovative methodology developed in this thesis, towards the development of an explanatory framework for difficulties in communicating about and making sense of subjective experiences as depression. This contribution has been made through the development of the methodology of "Thematic Analysis" for the analysis of accounts as representations of experience. This methodology was developed to identify common themes in individuals' experiences, variability within and between individuals' accounts, and discourses used by individuals in accounting for their experiences are depression. The use of this methodology has emphasised the importance of an approach which moves beyond discourses and the text and looks at experiences and action. (See Part III, below).

PART II: A BRIEF REVIEW OF THE CONTRIBUTION OF THIS THESIS TO THE SOCIAL PSYCHOLOGY OF DEPRESSION

Part II briefly considers the contribution of this thesis towards developing a social psychological approach to depression, through which depression is explained as the dynamic experience of a person (see Chapter One, Part III). It draws on research literature on the psychology of depression discussed in Chapters One and Three.

1. Meaning

As discussed in Chapter One, Brown and Harris (1978) ignore the question of meaning. They claim to investigate the meanings of events but, constrained by their positivist claims to objectivity, they do not consider the meaning of events for those who experience them. Brown and Harris (1978) claim to explain depression in terms of the social environment, but they deliberately avoid any consideration of subjective meaning or subjectivity, and they fail to look at interactions between individuals and their social environment (see Chapter One, Part II, section 2; Chapter Three, Part II, section 1 and section 2.2; and Chapter Seven, Part I, section 3)

The research presented here has demonstrated that subjective meanings of events are complex, are incorporated into experiences of depression and are vital to understanding the nature of experiences of depression. Although Brown and Harris (1978) suggested that a more detailed study of women's experiences was necessary, they also claimed to have laid down a framework for this, and their own subsequent research work (e.g. Brown and Harris, 1989) is based on the methodology of their 1978 work. However, the research presented in this thesis has demonstrated that a radically different approach and methodology is needed, in which the focus of research becomes the subjective meaning of experiences, and the methodology focuses on the analysis of subjective accounts.

Brown and Harris (1978) ignored the person except as the location of depression (Chapter One, Part II, section 5). Research presented in this thesis has demonstrated that social factors cannot be considered as distinct from their meaning to the person, and that meaning is constructed through social experiences.

2. The construction of gender identity

2.1 The construction of gender identity and the construction of self.

The analysis of subjective experiences of depression presented here has included consideration of the construction of self and identity, consideration of experiences of

gender and the social construction of gender identity, and the question of how social experience is incorporated into the individual.

Depression is an experience of self, as suggested by Jack (1991). An analysis based on Mead's (1934) theory of social behaviourism has been used in this thesis to consider questions of meaning. Jack (1991) assumes that self is experienced through relationships on the basis of Gilligan's (1982) work on women's relational self (see Chapter Three, Part II, section 5.2). Research in *Study IV* suggested that women may be defined *by others* in terms of meeting the needs of others in relationships and *thus* experience themselves in terms of these relationships. Research for *Study IV* in this thesis has demonstrated that women experience themselves negatively in relationships which reflect and reproduce ideal constructions of women, and that these constructions form the "other" against which women are judged. This "other" is seen, for example, in the idealisation of wives and mothers, ideals which reflect wider social values and gender constructions, which women cannot actually meet but against which they are judged and judge themselves as failing.

The data analysis presented in *Study II* and *Study IV* suggested that social constructions of gender identity are incorporated into the self, but that individuals do not simply internalise them but actively reflect upon them. Data analysis in *Study IV* suggested that socially constructed gender ideals are both rejected and used as a measure against which women judge themselves as adequate or inadequate mothers, partners and women. Data analysis in *Study II* suggested that men may equally incorporate social constructions of gender identity into their constructions of self, although since more women have been interviewed more has been said about women's experiences in this thesis. For example, men interviewed in *Study II*, as patients diagnosed as depressed, contextualised or explained their depression in terms of unemployment. This suggested that employment may be critical issue in the construction of adult male gender identity. (Since the women interviewed were full-time mothers the implications of paid employment for female adult gender identity have not been discussed, except to note that loss of employment may contribute to loss of independence and autonomy for women).

Depression in women has been explained in terms of dependency on others (Birtchnell, 1988). It has been argued (Cadbury, 1991) that this is to ignore what women actually do experience, and to mistake dependency for women's functional behaviour within their roles. (See Chapter One, Part II, section 6). The research presented here suggests that women's experiences of depression may be better understood in terms of how women construct a sense of self through intimate relationships, often with men, and through internalising and reflecting upon men's behaviour towards them in relationships. Women

may be unable to challenge this behaviour, to move out of relationships or attempt to construct new roles for themselves, because they are trapped within social constructions of acceptable women as those who meet the needs of others, particularly men. (See Chapter Eight, Part II, Part A).

2.2 The construction of gender identity: Explaining depression as loss of self.

Oatley and Bolton (1985) argued that depression can be explained as loss of self, where sense of self is maintained through a key role relationship (see Chapter One, Part II, section 4). Oatley and Bolton (1985) explained the self as maintained through a key role, rather than conceptualising the self as complex and multi-dimensional experiences, constructed through many relationships, and variable and dynamic. Research presented in this thesis suggests that depression cannot simply be explained as loss of role and is more complex: that roles are themselves given meaning through relationships which also draw on and reflect wider social meanings.

Neither Oatley and Bolton (1985) nor Brown and Harris (1978) consider the question of gender (see Chapter Seven, Part I, section 2). Brown and Harris (1978) argued that depression could be explained in terms of role identities but claimed that it was then related to social structure (see Chapter Seven, Part I, section 2.1.4). This ignores the importance of the individual's experiences. (See also Chapter One, Part II, section 4.1). But the underlying question may be: what is meaningful in the construction of self and what renders this meaningful? For example, how is motherhood rendered meaningful for women within constructions of female gender identity?

The ways in which women construct themselves as mothers draw on wider constructions of female gender identity. The social construction of gender may determine that specific roles are central to a person's gender identity and so may determine the meaning of those roles. It may be that women can only achieve what is socially constructed as female maturity through motherhood. (See Chapter Seven, Part II). Persons may experience loss and depression when they fail to maintain or fulfil roles in a way which is consistent with social constructions of gender identity. Women interviewed in *Study IV* constructed their identity as women in terms of their roles as wives and mothers, but this conflicted with their desire for autonomy and independence (see Chapter Eight, Part II, Part A, sections 4, 5 and 6). A loss of identity and self may be inherent within contradictory constructions of gender.

The construction of gender identity itself may be contradictory and cannot be fulfilled, within conflicting demands of roles and relationships which cannot be met. For example, women are unable to meet ideal constructions of motherhood, to be both self-sacrificing

and fulfilled, to achieve autonomy and independence and fulfil themselves through meeting the needs of others in relationships. (See Chapter Seven, Part II, section 1.3; and Chapter Eight, Part II, Part A, sections 4, 5 and 6.)

3. The social environment

It has been argued here that it is not the social environment which is important in explaining depression but a person's experience of the social environment and the subjective meaning of that experience. It has been shown that depression may be explained in terms of the meaning of events to individuals. It has been argued that individuals actively reflect upon and construct and reconstruct the meaning of present and past experiences, that meanings are formed in interactions with others and that they are constantly reconstructed through reflection on subjective experience. Giddens' (1979) concept of durée has been used to explain subjectivity as an ongoing process, whereby meaning is constantly constructed and reconstructed from a person's particular biographical point and their position in the social structure.

Models of depression which avoid the question of subjectivity reduce the problem of depression to cognitive constructs or cognitive processes, locating it within the individual (see Chapter One, Part II, section 2). For example, Beck (1967, 1971) assumes that nothing in the social environment can lead to depression as a normal reaction and, given his assumption of psychopathology, locates the problem of depression in the individual (see Chapter One, Part II, section 2). By contrast, Brown and Harris (1978) attempted to explain depression in terms of the social environment, in a model of the social causes of depression (see Chapter One, Part II, section 1). Yet Brown and Harris (1978) also draw upon a cognitive mechanism, low self-esteem, and use cognitive sets to explain why some individuals become depressed and not others (see Chapter One, Part II, section 2.1). They conceptualise the social environment in terms of life events and explain the variable impact of life events on individuals through "vulnerability factors", but they do not look at the meaning of events to individuals who experience them.

Coyne locates the problem of depression within the social environment and within patterns of interpersonal behaviour (Coyne, 1976; Coyne, Aldwin and Lazarus, 1981; Coyne and Bolger, 1990). But he does not explain the meaning of interpersonal behaviour to the individual nor how it is incorporated into the individual's experiences. He does not look at the question of what the subjective experience of depression is, since he argues that depression must be objectively defined using diagnostic criteria (Coyne, 1994). He is constrained by his adherence to positivism from investigating the meaning of depression, from asking what depression means to the person who experiences it, and

from asking how interactions with others are incorporated into a person's experiences of depression.

Mead (1934) argued that the self is constructed through interactions with others. He does not take full account of complexity of the social environment. Mead takes no account of power relations, in his concept of the "generalised other" (see Chapter Three, Part II, section 5.1), but assumes a social consensus, and that the individual internalises shared social values. However, analysis of interviews in this thesis indicated that the problem is more complex, and that rather than sharing a social consensus individuals position themselves in relation to dominant values which they may both accept and reject.

Rather than the "generalised other", the "other" may be seen as both generalised and fragmented, as the dominance of social values in relation to which individuals position themselves in different ways. Persons do not simply learn consensus values as suggested by Mead (1934), but position themselves in relation to dominant and competing values, ideologies and discourses (see Chapter Three, Part II, section 5.1). Individuals' experiences may not be adequately accounted for through dominant social discourses and this is seen in contradictions in accounts. Dominant discourses may be used, implying consensus values, because no alternatives are available.

For example, women interviewed in Study IV both constructed motherhood as fulfilling, on reflection, and in their accounts of their daily lives as mothers constructed motherhood as a problematic experience, where their own needs were often denied and experienced as contrary to those of their children. As another example, the medical discourse of depression as pathology was powerful for patients in validating depression as a real problem, but was rejected by patients and non-patients as a description of their experiences as they avoided its pathological implications. It was challenged by psychiatrist Dr. P., in Study III, as inappropriate. So while a shared discourse of depression as pathology could be identified, this was not used by all participants in the same way.

PART III METHODOLOGY

The methodology of "thematic analysis" was developed through the research studies presented in this thesis. It is considered here (*PART A*) as a development of the theoretical perspectives and methodological techniques drawn upon in this thesis. Compromises made in the thesis research, and further possible developments of the methodology in order to address some issues raised in the thesis, are also discussed (*PART B*). The process of research is then considered as a personal process, in a reflective account of my experience of the research (*PART C*).

PART A: THE DEVELOPMENT OF THEMATIC ANALYSIS

The methodology of "thematic analysis" has been developed in this thesis to look at subjective experiences of depression and at the socially constructed meaning of the term "depression". Methodology was developed throughout the thesis, as appropriate to the research questions of each study. Earlier research formed the basis of further developments in methodology. (Further details of the mechanics of the methodology are given in Appendix B).

For example, in *Study I* (Chapter Two) the methodology developed away from an approach based primarily on *discourse analysis* (Potter and Wetherell, 1987), towards an approach in *Study II* (Chapter Five) which, while incorporating discourse analytic techniques, looked at *themes in an individual's experiences*. This was developed as "Thematic Analysis". Thematic analysis was further developed in *Study III* (Chapter Six) in looking at themes across health professionals' interviews with greater emphasis on *common themes across interviews in professional groups* (psychiatrists, G.P.'s and clinical psychologists). Methodology was developed through the process of analysis, for example professional identity and expertise had emerged in earlier stages of analysis in *Study III* as an important issue in explanations of and treatments for depression. Thematic analysis was then further developed in *Study IV* (Chapter Eight). Here *themes in individual women's accounts of their experiences* and *common themes in their experiences as mothers and as women* were identified and discussed, with reference to the social construction of gender identity and common themes in the construction of accounts by individual women.

The methodology developed has thus attempted to incorporate both the individual and the social, to move beyond a dualist perspective, and to look at how individuals incorporate and make sense of their experiences in the social world through the processes of

subjectivity and reflexivity. The research has followed a social constructionist argument, that terms acquire meaning and a social reality is constructed through processes of social interaction (Berger and Luckmann, 1966). It follows symbolic interactionism (Mead, 1934; Blumer, 1969) in arguing that meaning is constructed through reflection upon experience, using socially learnt language and incorporating social values, and that the self is constructed through reflexivity as the person becomes an object to themselves. It addresses the construction of meaning as both a social process and a personal process, since socially constructed meanings are seen to be drawn upon in, and reconstructed through, individuals' reflections upon their experiences.

The difficulties and advantages of the methodological techniques developed in this thesis are discussed below. The development of the methodology as a basis for an analysis of subjective accounts is discussed, an analysis which recognises the incorporation of social experiences into subjectivity and identifies common themes in individuals' experiences, while also maintaining a focus on depression as the experience of the *person.*

1. Commonality and variability

The methodology of thematic analysis has been developed to identify issues of *variability* and *commonality.* These issues have been addressed through the analysis of accounts on a *within interview* as well as *across interview* level and through the identification of *common social discourses* across accounts, and *common themes in experiences.* The methodology has been developed to address *variability between and within accounts.* The methodology of thematic analysis has been developed to incorporate within interview analyses, focusing on individuals' accounts of their experiences, into across interview analyses which identified common themes and discourses across accounts.

2. Interpreting accounts as representations of experiences.

Discourses and *themes* have been identified in accounts. The focus of the analysis is both experience and the ways in which experiences are constructed within accounts. Accounts are treated as partial representations of experiences. Since accounts are interpreted as representative of experiences, the analysis is not limited to the text, but seeks to move beyond the text in order to look at what *experiences* are, at least partially, *represented in the interview account,* how they are *interpreted* within the account, and their *meaning for the person* accounting for their experiences.

A key research aim was to investigate depression as the *dynamic and meaningful experience of a person.* Persons actively construct accounts of their experiences within interviews, and they attempt to make sense of their experiences. The aim was to investigate what is subjectively experienced as depression. Subjectivity is understood as

incorporating issues of both what a person experiences and the meaning of those experiences to them.

Thematic analysis has been used to identify themes in accounts, drawing on both across and within interview analyses, which look at both what is experienced and how experience has been interpreted, at both individual and common levels. Discourse analytic interpretative techniques and the approach of grounded theory (Henwood and Pidgeon, 1994, 1995) to the analysis of experience, have been drawn upon in developing the methodology through the research studies presented in this thesis.

2.1. The interview process.

The experiences represented in the interview and the account itself are the product of past interactions which occur outside and within the interview relationship. The production of an interview account is a dynamic process, which depends on the interaction of interviewer and participant within the interview, and the interview is itself constructed within that particular relationship. While the interview process has not been the major focus of analysis, awareness of the interview process has been incorporated into the analysis. For example, reflexivity can be identified within the interview itself. Chris, interviewed in *Study II,* reconstructed his experiences as depression through the interview process. I was also aware that I drew upon my own experiences of the interviews and my interview relationships with participants, in interpreting accounts. For example, the personal experience of the interviews gave me a sense of responsibility to participants, to acknowledge their standpoint in the interpretation of accounts, and to interpret interviews in a way which would be meaningful to participants although also moving beyond their standpoint (Henwood and Pidgeon, 1994) (see Part C, below).

3. An interpretative approach to investigating the meanings of experiences of depression.

The methodology of thematic analysis has sought to investigate the meanings of experiences of depression, identifying commonalities and variabilities in meanings, through an interpretative analysis. The development of the methodology has drawn upon concepts and techniques within grounded theory. But it is difficult to see how it would have been possible to take such an interpretative approach to investigating the meanings of experiences of depression using *only* grounded theory. The emphasis within grounded theory is on what is experienced, rather than how experience is interpreted (Glaser and Strauss, 1967) although a social constructionist version has been developed (Charmaz, 1990; Henwood and Pidgeon, 1994).

4. The construction of self in experiences of depression.

The research for this thesis has drawn upon social constructionism in investigating depression as a socially constructed and emergent reality shaped by social interactions (Berger and Luckmann, 1967; Charmaz, 1990). The methodology of thematic analysis has been developed to look at depression as a socially constructed experience, but with an emphasis on the subjective meanings of experiences for individuals and on how individuals make sense of their experiences. The emphasis has been not only on socially constructed meanings of depression but on subjective experiences of depression, and on how individuals draw upon socially constructed meanings in constructing their accounts of depression.

It would have been difficult to achieve an emphasis on the person who experiences depression, drawing only on social constructionism. The research analysis presented in this thesis has attempted to investigate how individuals make sense of their experiences as depression, and how the self is constructed as depressed. This has been achieved through drawing on Mead's (1934) theory of social behaviourism, where the self is explained as constructed through interactions with others and through the process of reflexivity, where the self becomes an object, the "me" of past experience (see Chapter Three, Part II, section 3). For example, depression has been explained as an experience of oneself as unacceptable to others and as the construction of oneself as inadequate within relationships with others. (This was seen, for example, in interviews in *Study IV* with women whose partners constructed them as inadequate mothers).

The emphasis on subjective interpretations of experiences of depression has led to a focus on contradictions within individuals' accounts, which have demonstrated tensions between the socially constructed meanings of the term "depression" and what individuals actually do experience as depression. For example, the term "depression" carries clinical connotations, and participants can be seen to both use and reject the term as they validate their experiences as depression and reject the pathological implications of calling their experiences depression.

5. Discourse analytic techniques

A realist position is adopted to the experiences represented in *relative* accounts (see Chapter Three, Part IV, section 1.2). The original version of grounded theory (Glaser and Strauss, 1967) has been criticised as a positivist approach which suggested a single version of experience, although this is not necessarily inevitable in the use of grounded theory (Henwood and Pidgeon, 1994). Discourse analytic techniques (Henwood, 1993) are used in this thesis to investigate accounts as interpretations of experiences. The person is understood as active in constructing a relative or partial account of their

experiences, and as drawing upon personal, local and wider socio-cultural resources in interpreting their experiences through shared language and linguistic constructions (Henwood, 1993). Deconstructive analysis involves making these resources explicit, and uncovering hidden meanings or values (Henwood, 1993; Henwood and Pidgeon, 1994).

The methodology of thematic analysis has been developed to analyse accounts at an individual as well as social level, and to explore what the individual has experienced as well as how that experience has been constructed within accounts using available discourses. The emphasis has been on depression as the experience of a person, and on the account as a personal and subjective construction and representation of experiences. The person has been considered as the user, and producer, of discourses, in accounting for experience, and not merely as positioned in relation to discourses. The following points are made in relation to the use of discourse analytic techniques in this thesis:

5.1. Common social discourses.

Discourse analytic techniques have been used to identify, across interviews, *common social discourses* which individuals draw upon in accounting for their experiences. Social discourses are interpreted as reflecting socio-cultural values. One powerful discourse which has been identified throughout all studies, despite differences in age, gender, and experiences of participants, is the medical discourse, through which depression is constructed as a clinical condition, and which reflects and reproduces the power of the medical profession.

5.2. Individuals actively use and construct discourses.

Within this thesis, discourse is not merely understood as a linguistic construction, as argued by Potter and Wetherell (1987). Accounts of experiences are actively constructed by individuals who draw upon, reject and seek to reconstruct powerful social discourses, in reflecting upon and accounting for their experiences. The individual is not merely positioned in relation to discourses, as argued by Potter and Wetherell (1987). Discourse is both a social resource and a personal and individual construction, in that individuals may use discourses in different ways within accounts and they may vary in the ways in which they use discourses to interpret their experiences.

For example, Ros, a mother interviewed in *Study IV*, both rejected the pathologisation of the term "depression" and, based on her own experiences, reinterpreted the word "depression".

Siân: Yes. Um, so you, would you say you still get depressed now or - ?
Ros: Um, well I have a little difficulty with the word "depression".
Siân: Oh yes, what do you think it means or - ?

Ros: Yeah, um, well, sort of, I think, yeah, I do get depressed, but I think it's kind of, like a layer in my experience because I can feel happiness at times but I've got this, like, layer of undealt with stuff.

5.3. Discourses are constructed and acquire meaning through social interactions.

In this thesis, discourses are understood as constructed by persons engaged in social interactions, through shared social experiences, and through individual reflection upon experiences. Discourse is understood as both a medium and product of social interaction and experiences. It is not a pre-existing given, whereby experiences are interpreted, and in relation to which persons are positioned.

For example Mary, interviewed in *Study I*, a woman in her twenties who had a history of depression from childhood, described how her interpretation of herself as depressed changed when a friend suggested that she might be ill:

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, it wasn't my fault, you know... it gave me a completely new aspect on, on the way I was.

However, she has found that the notion of illness does not bring her respect and understanding from other people. Through her experiences, her understanding of the implications of calling depression an illness has developed to take account of several possible meanings of "illness":

Mary: I just wish people could see, um, mental illness in-, obviously it's not the same kind of illness but on the same kind of, um, with the same kind of respect really [as physical illness].

5.4. Discourse, social structure and action.

Discourse is formed through social interaction. Contradictions in the use of discourses in accounts may be explained through a focus on social structures and organisations. For example, it has been shown that medical discourses, as used by clinicians in *Study III* (see Chapter Six), are insufficient in accounting for subjective experiences of depression. How are the gaps, between the discourses of clinicians and accounts of subjective experiences of depression, to be accounted for? It has been suggested that clinicians' discourses of depression as illness may reflect the values and structures of social organisations, specifically the health service, through which help is provided for depression, and within which medical values predominate. It has been suggested that if the only readily available help is medical treatment, then depression will come to be defined as a medical condition. (See Chapter Nine, Part II, section 3.)

6. Summary of thematic analysis

The methodology of thematic analysis has been used to investigate meanings of experiences of depression, where experiences are understood as partially represented and interpreted by participants within interview accounts. It should also be emphasised that the data analyses presented in this thesis are interpretative and are not conclusive nor comprehensive.

6.1 The methodology of thematic analysis which has been developed has addressed both commonality and variability: common themes in experiences of depression and common discourses in accounts of depression, and the variability between and within individuals' accounts of experiences of depression. Common themes in experiences of depression and variable subjective dimensions of experiences of depression have both been discussed.

6.2 While experiences may be interpreted and accounts may be constructed using shared social discourses, it has been shown that these discourses are used in different ways by individuals. While depression may be a common experience and while there are common elements in what is experienced, it has been shown through analyses of subjective accounts that experiences of depression have variable meanings for individuals, and that experiences are interpreted by individuals with reference to their particular histories and social positions.

6.3 The development of thematic analysis was informed by readings of Mead's theory of social behaviourism (Mead, 1934), readings of symbolic interactionism (Blumer, 1969), readings of grounded theory (Glaser and Strauss, 1967; Strauss and Corbin, 1990; Henwood and Pidgeon, 1994, 1995) and readings of social constructionism (Berger and Luckmann, 1966; Charmaz, 1990).

All the above approaches are drawn upon and it is difficult to see how any single approach could have produced the same analysis. It has been essential to draw on all these approaches, as complimentary approaches, in the research presented in this thesis. For example, briefly and as argued above:

> i. Grounded theory (Glaser and Strauss, 1967) emphasises what is experienced but not how experiences are interpreted, and does not address processes of interpretation and reinterpretation within accounts; discourse analytic techniques are therefore incorporated into the methodology of thematic analysis to facilitate an analysis of how experience is interpreted.

ii. Discourse analysis (Potter and Wetherell, 1987) emphasises interpretation in a relativist approach to accounts of experience but does not address the question of what is experienced as a reality and does not take account of the person as active in interpreting and reflecting upon their experiences.

iii. Social constructionism (Berger and Luckmann, 1966), does not focus sufficiently on the subjective and reflexive construction of meaning.

iv. The research in this thesis has attempted to recognise the *complexity* of meaning and the *complexity* of subjectivity, as an on-going process of interaction within the social world and as the product of social processes. Mead's (1934) theory of social behaviourism has been important in the development of the theoretical basis of this thesis. However, analyses using the methodology of thematic analysis have demonstrated that the relationship between the individual and the social world is more complex than Mead (1934) suggested. In particular, it has demonstrated that in the concept of the "generalised other" Mead (1934) underestimated the complexity of the social world, assuming consensus social values and taking no account of power relations (see Chapter Three, Part II, section 5). Analysis of discourses used and themes constructed in accounts has shown that individuals draw upon multiple and contradictory discourses in interpreting their experiences.

Thematic analysis can be summarised as enabling the analyst:

i. To move beyond the text and to focus on what is experienced as well as how experience is constructed within accounts.

ii. To focus on depression as the dynamic experience of a person.

iii. To become aware of social and structural issues in individuals' experiences as presented in accounts

iv. To show that the construction of meaning is both social and subjective, in identifying common themes and discourses and variability in themes and discourses within and across individuals' accounts.

PART B: DEVELOPMENTS OF THE METHODOLOGY AND FUTURE RESEARCH

1. Explaining depression as the experience of a person

Thematic analysis has been developed to identify themes and discourses within interviews, and to incorporate these into the analysis of themes and discourses across interviews. Thematic analysis has been developed to combine the benefits of within and across interview analysis, to look at variability in individual experiences within interviews and across interviews and to combine this with an awareness of common experiences.

Analysis within interviews enabled a focus on how participants developed themes, how they constructed and drew upon discourses, and how they related themes and discourses. Analysis within interviews enabled a detailed investigation of the meaning of depression as a personal and subjective experience and as an experience of self. Analysis across interviews was used to identify common themes, and variability within common themes, and to demonstrate how common themes were constructed in different ways across accounts, building on within interview analyses.

Case studies were used in *Study II* (see Chapter Five), in order to investigate the variability of experiences of depression among patients of general practitioners, to examine in more detail and more depth how individuals experienced and accounted for depression, and to explore variability within interview accounts. However, within the thesis as a whole the use of case studies alone would not have shown the commonalities across accounts to a sufficient extent. A case study approach would have been inadequate given the focus of this thesis on the social construction of depression.

The development of thematic analysis has been important in establishing that depression is a common experience, though depression is experienced as individualised and though it is not a shared experience. Thematic analysis has been important in identifying common experiences, and common themes in interpretations and constructions of experiences as depression. For example, and as discussed in Chapter Nine, Part II, section 1, above, it has been important to identify that a common experience in depression is feeling apart from, different to and isolated from others, and that being labelled as depressed, within a clinical discourse, may itself reinforce this experience.

But the movement from within interview analysis to across interview analysis, in *Study I*, *Study II* and *Study IV* in particular, meant that some of the details of within interview analysis, of individuals' accounts of their experiences and of their interpretations of their experiences, were inevitably lost.

An ideal method may have been to combine case studies with cross-sectional thematic analysis. For example, the presentation of case studies as well as cross-sectional thematic analysis in *Study IV* would have enabled demonstration of the range and variability of women's experiences and women's accounts of their experiences, of the ways themes and discourses were linked within different accounts, and a more in-depth analysis of contradictions within accounts. But this was impossible given time and space constraints, and the research has demonstrated variability between individual interviews and across interviews, though with less emphasis than might otherwise have been achieved on processes of construction and interpretation within interviews.

2. Developing thematic analysis in longitudinal case-study designs for the investigation of depression as an on-going process.

The emphasis in the research has been on explaining depression and interpretations of depression. It has been argued that depression can be understood as a process. However, the research design has been cross-sectional, and further research using a longitudinal design might be useful for further clarification of some of the issues identified in this research and for addressing depression as a process. Examples of possible studies are given below.

2.1 The construction of depression as a past experience.

Individuals interviewed constructed retrospective accounts of their experiences of depression. Depression was sometimes identified *only* retrospectively in interviews (for example, Chris in *Study II*, Penny and Fran in *Study IV*). It has been argued that this may be an avoidance of the pathologisation implicit in saying one is currently depressed. (See Chapter Nine, Part II, section 2.1.5).

The identification of depression as a past experience may be important in coping with experiences of depression. Individuals may learn to cope with depression through experience of depression as something they move in and out of. Depression may then be accepted as part of life, and individuals may learn to cope with depression as something which may recur but not last forever. For example Fran, interviewed in *Study IV*, said that she was not depressed at the time of the interview, that she expected to become depressed again, but that every time things became easier and better as her life improved overall. John, interviewed as a patient in *Study II*, said that his experiences had changed as he had learnt to cope with depression, which he had suffered since he was in his twenties (he was in his fifties), and since he had learnt that depression was something he would come out of again (see Chapter Five, Part II, Interview 2: John, section 1.2).

Giddens' (1979) concept of durée takes into account the individual's particular social position and their point in their life history, and suggests that identity and meaning are ongoing processes which evolve over time and which are dynamic not fixed. (See Chapter Three, Part II, section 2.2; and Chapter Eight, Part I). A longitudinal case study design, where individuals are interviewed and re-interviewed, could be used to further investigate the process of depression, examining how interpretations of self and the meanings of depression are dynamically constructed and develop over time. This would enable a fuller investigation of depression as an on-going and variable experience. It would also provide an opportunity to take the researchers' interpretations back to participants as part of a joint process of interpretation, in which reflexivity could be further explored.

2.2. The development of medical discourses surrounding depression.

Study II investigated the use of medical discourses by patients in accounting for their experiences as depression, and in *Study III* health professionals were interviewed as possible sources of the medical discourses used by patients.

Questions which can be identified from *Study II* for further research include the extent to which, over the treatment period, patients internalise and draw upon clinical discourses in interpreting and making sense of their own experiences of depression. A further question is the extent to which patients internalise the discourses of a particular professional involved in their care, or of particular professions involved in their care, through treatment. As discussed above (Chapter Nine, Part I, section 2), how patients make sense of the diagnosis of depression is an important issue in treatment and has implications for the construction of the self as depressed.

Questions for further research, developed from *Study III,* include the extent to which clinicians' discourses develop through their interactions with their patients. Longitudinal case study designs, including interviews with prospective patients and their clinicians before consultation and over the treatment period, would enable a more detailed and in-depth investigation of the development of discourses surrounding depression, as used by patients and clinicians.

2.3. The evolution of shared discourses surrounding subjective experiences of depression.

Karp (1992) found that members of a self-help group for depression developed a shared rhetoric through which they made sense of their experiences. Analysis of interviews in *Study IV* has indicated that the recognition of shared experiences may be important for women, and that women's constructions of themselves as inadequate may reflect their

isolation. It has been argued in this thesis that part of the problem of motherhood is that women do not know if they are alone in experiencing problems (for example Penny, see Chapter Eight, Part II, Part B, section 3). Participants suggested that sharing experiences with other women was helpful. On the other hand, while sharing experiences might be useful, this clearly took time to evolve: Cate said that she was able to "let herself go" with other women (see Chapter Nine, Part II, section 2.1.3), but that in a self-help group for single mothers she had been unable to talk about her problems because she felt that they were not real (see Chapter Eight, Part II, Part B, section 3). Mary, interviewed in *Study I*, argued that people who had had similar experiences to her own had a kind of "intuitive understanding" of her experiences of depression.

The evolution of shared discourses of depression among individuals likely to have had some common experiences could be further investigated using a longitudinal design: for example, using repeated individual interviews with women attending a support group, such as that from which participants for *Study IV* were recruited (see Chapter Eight, Part I). Alternatively, repeated group interviews might be used, minimising the role of the researcher in the discussion, although this can present practical problems in the interview process and in the transcription of data (see Chapter Two, Part III, section 2.1).

PART C: A NOTE ON RESEARCHER REFLEXIVITY: MY PERSONAL EXPERIENCE OF THE RESEARCH PROCESS.

This research has also been a process of personal and academic development, and some issues arising from my personal experience of the research are considered below.

1. Training in social science research

Part of my training in the course of the research has been to question the values of mainstream psychology, and to continue to reapply these questions throughout the research process. My social science training, my training in mainstream psychology, and my assumptions about the scientific research process as one leading to conclusions supported by statistical tests, were simply not appropriate to the data I was addressing, nor indeed to the questions I was asking.

Several issues have emerged during the process of research. First, I had no tradition on which I could base my work, and in particular I had no format by which I could lay out my thesis nor accepted guidelines as to the specific way my work should be presented. Second, part of my research training seemed to be to recognise that the data were indeed difficult to manage, and to evolve a method of analysis and presentation which would reflect this difficulty while making it comprehensible to the reader.

Several times I have reached "dead" areas in the process of analysis and writing up, where I have been aware of the richness of the data and of the many themes identified within the data, and yet I have felt totally "blocked" and unable to write. This occurred as I attempted to construct analyses which supported and led to clear conclusions. It seemed as if I was "destroying" the data as I tried to fit it into categories, to superimpose themes, to push it into a neat analytical model where it simply would not fit and which removed the richness and complexity of the data. I was positioned between imposing a simplified structure of analysis, which ignored the complexity and failed to do justice to the richness of the data, or being faced with complex data which was difficult to handle, and of which I feared that I might be left saying nothing.

One solution was to recognise that the data is complex and difficult and to recognise that I could not reach conclusions nor present my data and analysis in a conclusive or comprehensive manner, but that I could explore issues and identify further questions for research. Thus I needed to develop a method of analysis which took account of the complexity and variability of the data, while making sense of it, and a way of writing up and structuring the research account which clearly guides the reader through the data analysis, while also demonstrating its complexity.

The research process is a reflexive process. Throughout the research and writing up processes, I have developed my personal perspective on psychology and in particular the psychology of depression. In doing so, I had to recognise and learn to live with uncertainty and confusion, as part of the process of research, with its consequent stress. Marshall (1989) has similarly referred to her own difficulty in containing the uncertainty of the research process and the anxiety this causes. This may be particularly acute during the Ph.D. process where one feels that one's research ability is tested at the same time as it develops and where uncertainty and anxiety are seen as an inevitable part of the process (Nicolson, 1988; Salmon, 1992).

The research account presented in this thesis is not definitive, nor comprehensive. One problem has been deciding when to draw each stage of the research to a close, in terms of interviewing, analysis and writing up. There are too many issues contained in the data to do justice to all. What has been presented here is a scientific analysis of those issues identified as most significant to the psychology of depression, given the research questions developed throughout the studies presented in this thesis.

2. Involvement in and commitment to the research

My experience in researching for and writing this thesis has suggested that the pursuit of qualitative research is by definition emotional, stressful and personally meaningful for the researcher, that it is through these characteristics that the research achieves meaning and significance, and that these characteristics are an essential element of the research account. The difficulties of the research process have suggested that reflection on the subjective meaning of the research to me as researcher has enabled me to move the process of research forward, and that my awareness of my relationship to the data is an important element of the interpretative process.

Essential to this research have been my feelings of personal involvement in and commitment to the research, and the responsibilities I have felt as a researcher towards participants in the research projects. These were largely indistinguishable. To some extent, I have also experienced my perceptions of my responsibilities to the participants and my goals in the research project as conflicting.

It has been difficult to maintain my involvement in the research at a level which is constructive but not overwhelming. For periods of the research and writing of this thesis, I have felt overwhelmed by the emotional content and meanings of the data. This often left me feeling completely disempowered and paralysed in relation to the research and unable to move the research process forward. I have felt both highly committed to the

academic and scientific importance of this research and yet at the same time wished I could simply walk away from it or approach it in an more distanced or "objective" manner, (even using questionnaires!). As a result, there have been periods in the analysis when I have sought to take a more categorical approach. At these times I felt that I was both losing sight of the purpose of the project and the research questions. At times it has been difficult to stand back and regain an informed sense of my own perspective on the research.

However, I was rarely conscious of the implications of this experience, and I did not validate it as a problem in the research process, until it became more evident as I wrote the thesis up.

2.1 Responsibilities towards research participants.

Although this is an academic project, inevitably I had some sort of personal relationship to the participants interviewed since I conducted each interview. During and after the interviews, I was aware that the degree to which I felt each interview had been successful depended on my relationship with the participant and the extent to which it seemed it had been a meaningful interaction for both of us.

Certainly I felt at the time of the interviews that they had opened up important research issues. I was also often aware that the interview was a potentially constructive process for some participants. Clearly for some the interview was a rare chance to talk about their experiences, to reflect upon them and to some extent reinterpret their experiences. Several participants said that they had enjoyed it. In particular, the mothers interviewed about their experiences of depression in *Study IV* said that they were glad to have a chance to talk. A health visitor involved in contacting participants for *Study IV* said that the women themselves were keen to be interviewed and that it was "great therapy", which was both encouraging and somewhat alarming. I was surprised and gratified by the extent to which most participants had opened up about experiences which were so difficult and personally meaningful.

I felt a considerable degree of responsibility as an interviewer and as a researcher to participants, to do their accounts justice in the analysis and writing up of the research. (See also Oakley, 1981a). Since they had told me of their lives or parts of their lives, I felt responsible to make sense of their accounts in a way which would be meaningful to them. This was more acute since I felt in a privileged position as a researcher, as through the interviews and analytic process I became more aware of the commonality of participants' experiences, which they were often not aware of, and of their extreme

isolation and sense of marginalisation and hopelessness. This was particularly true in the research for *Study IV.*

The personal relationship of the interview extended into my analysis of the interview data. In the process of analysis it has been difficult to let go of the accounts, to lose responsibility for them and also achieve some sort of emotional distance from them. Whereas the interview itself had been a dynamic and interactive experience, interpretation was isolated and analysis sometimes became "stuck". My reading of the transcripts was informed by my vivid memories of the interview, and I had also made notes of my experiences after each interview. But during the analysis of the data I often felt trapped within the terms of the account and the analytic process often became static.

2.2 My personal involvement in the research issues.

The extent to which I empathised with the participants became both an important factor in motivating the research and also an oppressive emotional burden. Here I consider this in relation to my experience of working on *Study IV*, interviewing mothers about their experiences of depression, since this was the most extensive study and the one in which I felt most personally involved.

First, since most of the women interviewed experienced themselves as powerless and felt that their experiences were ignored, I felt some responsibility as a psychologist to make sure that they were given a voice through my research and that their experiences were validated and given voice through a competent analysis. Similarly, Oakley argues for doing research for rather than on women (Oakley, 1981a). But I also felt relatively powerless myself as a postgraduate student, attempting to meet the criteria for a Ph.D.

Second, my position was different to that of most of the women interviewed since through my education I had opportunities to be more articulate than they were, while I was also able to empathise with some of what they were experiencing.

Third, in attempting to make some psychological sense of their experiences I could not avoid addressing the issue of what motherhood is. This was necessarily both personally meaningful to me and problematic for me, as a woman who was not a mother. Motherhood was not a personal experience upon which I could draw in attempting to understand their accounts. But it was an experience I could react to as a potential experience and as part of a shared construction of female identity. My assumptions surrounding notions of female identity and the construction of motherhood were challenged by these first-hand accounts of experiences of motherhood. Readings of research literature and the interview accounts led me to rethink my assumptions about

motherhood, as I became more aware of what the experience of motherhood meant to these women, of common elements in that experience, and of how these contradicted popular notions surrounding motherhood. This also involved a sense of responsibility to challenge, through this research, popular notions and powerful social constructions of motherhood, of female identity and of depression in women, and this has itself at times been almost overwhelming.

3. Summary

Thus I was often positioned between feelings of responsibility to participants and the need to both acknowledge this responsibility and free myself from it in order to move the research process forward. Making sense of my personal, and to some extent emotional, involvement in the research has become important as a resource for making sense of accounts, as something which can be both drawn upon and moved beyond. Research has been a reflexive process, an academic and a personal process, which is situated within and moves beyond accounts and which focuses on the person. The relationship between researcher and participants, and the meaning of the research to the researcher, are important elements of the research process, though not often acknowledged.

PART IV SUMMARY: THE CONTRIBUTION OF THE THESIS TO THE PSYCHOLOGY OF DEPRESSION

The findings of the research presented in this thesis will here be briefly summarised, building on the fuller discussion in Chapter Nine and earlier in this chapter.

1. The use of a qualitative methodology in research on depression

It has been shown that depression is a complex experience, which varies between individuals and in which common themes can be identified across individuals. The use of a qualitative methodology has enabled the researcher to start with the complexity of individuals' accounts of depression and to make this complexity the focus of the research. Accounts are contradictory, and a qualitative methodology has been used to investigate contradictions within accounts in an in-depth analysis. Experiences have been investigated at an individual level, and variability between and within accounts has been the focus of research.

For example, the research presented in this thesis has shown contradictions within individuals' accounts of their experiences of depression. Individuals contradict themselves and are ambivalent in describing their experiences as depression. It has been argued that the term "depression" has pathological implications which individuals avoid and reject, but that there are few alternative ways of identifying problems as real depression. It is difficult to use the term "depression" without implying pathology and it is also difficult to construct an alternative and non-pathological discourse of depression.

2. The meaning of depression

Depression is very difficult to make sense of, both for the depressed person and for others. It has been shown that patients diagnosed as depressed were unable to make sense of their experiences as depression (*Study II*, see Chapter Five). A medical diagnosis and medical treatment may not be helpful in enabling individuals to make sense of their experiences.

However, some individuals interviewed did explain their experiences of depression, as a process of personal change. This was often through retrospective reflection on past experiences of depression. Depression was explained in terms of difficult relationships with others and withdrawal from relationships. Among mothers interviewed, depression was also described as a process of adjustment and change. (See *Study II*, Chapter Two; *Study III*, Chapter Five; and *Study IV*, Chapter Eight).

3. Depression explained as an experience of self.

Common themes have been identified in accounts of depression. It has been shown that there are common elements in the experience of depression, although depression is not a shared experience. It has been argued that an important common feature in experiences of depression is feeling cut off from others and unable to communicate with others about how one feels. Depression may be a feeling of "other", that one is different to others and unacceptable to others. It has also been suggested that part of the experience of depression may be feeling unacceptable to oneself. Part of the problem of depression may be a sense of difference, and this may be reinforced by the difficulty of communicating and explaining how one feels to others.

Depression has been explained as a loss of self, for example in analysis of accounts of women who were mothers (*Study IV*, Chapter Eight), as well as of accounts of patients diagnosed as depressed (*Study III*, Chapter Five). Analysis of accounts suggested that women lose their personal identity and freedom as they take on the social identity of a mother and as they sacrifice themselves to meet the needs of their children. Loss of their own identity and freedom was specifically identified as a problem by some women in reflecting upon their experiences and was implicit in the accounts of other women. Women may only be aware of a loss of their personal identity retrospectively, as they seek to reconstruct themselves.

In the research literature, depression in women has been explained in terms of their failure to satisfactorily fulfil their roles as wives and mothers (Brown and Harris, 1978), and depression has been explained with reference to men's experiences of unemployment as a loss of self occurring when a key role is lost (Oatley and Bolton, 1985). It has been argued in this thesis that depression cannot be explained simply as loss of self or in terms of roles. It has been suggested that Mead's (1934) theory of social behaviourism is important in developing the work of Brown and Harris (1978) and Oatley and Bolton (1985). Depression may be explained as an experience of the self as unacceptable to others and to oneself within social interactions and relationships. (The experience of the self as unacceptable may also incorporate the loss of an acceptable self, although it is not clear that some individuals have ever experienced themselves as acceptable so the argument of loss may be difficult to maintain). It is argued in this thesis that the construction of the self as unacceptable within social relationships is based on wider social values, in particular the social construction of gender identity.

While Brown and Harris (1978) argued that women's experiences of themselves in their roles as wives and mothers might be central to explaining depression in women, they did not go on to investigate why these roles might be so important. There is an implicit but

not explicit link, in Brown and Harris's (1978) research, between women's experiences of depression and the construction of female gender identity. This link has been developed by feminist researchers, who draw out the feminist implications of Brown and Harris's research while rejecting their methodology since it is not based on women's own accounts of their experiences (Stoppard, 1995). Jack (1991), using women's subjective accounts of depression, has argued that women experience themselves negatively through their relationships, where they are judged by others and judge themselves according to internalised male based values.

There is no simple social consensus, such as Mead (1934) implied in the concept of the "generalised other". It has been argued here that an approach based on Mead's (1934) theory of social behaviourism can be developed, to explain depression in both men and women as the construction of an unacceptable self based on dominant and contradictory social values. It has been argued that the self is experienced and constructed through drawing on contradictory social values and experiences. Individuals may become depressed as they fail to meet values which are both contradictory and dominant in society. This may be true in different ways for both men and women. For example, for men interviewed as patients in this study the experience of unemployment was problematic. However, since more interviews were done with women it has been possible to say more about women. For example, for women interviewed the experience of motherhood was contradictory since it was frustrating as a daily routine and was explained on reflection as rewarding, but these contradictory aspects of their experiences were inconsistent with the powerful, socially constructed version of motherhood as female fulfilment.

4. Explaining depression as a subjective experience.

There have been some limitations on the research presented in this thesis. It is impossible to directly investigate subjective experiences of depression. The use of a qualitative methodology for the analysis of subjective accounts can address the complexity of experiences more effectively than more mainstream positivist approaches, but subjectivity cannot be fully explored. Part of the problem of depression is that it is difficult to talk about and this inevitably has implications for qualitative research using accounts of experiences of depression, since the research is limited by what is talked about in accounts. However, it has been possible to suggest why depression is difficult to talk about, and it has been argued that difficulty in communicating how one feels when depressed is part of the problem of depression and is incorporated into feelings of difference from others.

Recognition of the importance of subjective experiences of depression means moving beyond the narrow, symptom based definition of depression as in the medical model, and implies a need to extend definitions of depression to take account of subjective experiences (Stoppard, 1995). The medical discourse of depression as pathology has been identified as a dominant discourse which fails to take account of the complexity of what individuals do actually experience as depression. However, as has been shown in this thesis, medical diagnoses are powerful and do validate and legitimate experiences as problematic, and thus may be experienced as helpful by patients. A broader understanding of what individuals do actually experience as depression has implications for diagnosis, treatment and health promotion.

Depression need not be understood as a medical problem, but may be better explained as a social problem, as an aspect of subjective experience which is both individual and social. It has been argued in this thesis, following Brown and Harris (1978), that depression is a social experience and that it need not be construed as pathology. However, it has also been argued that depression might be better understood as the experience of a person in social interaction, rather than in terms of social causes as in Brown and Harris' (1978) model, and that it is the meaning of social events for individuals which is important. Depression is a common problem which is also a social problem and not simply contained within the individual.

Greater recognition of what individuals actually experience as depression and of the meanings of experiences of depression, might enable a greater understanding of depression among health professionals and others who help those experiencing problems of depression, and among the general public. Persons experiencing problems of depression experience difficulty in communicating how they feel. Greater public awareness of depression as a common problem, and of what depression is, might lead to more support for and greater understanding of depressed persons within interpersonal relationships. Research presented in this thesis has shown that among health professionals there are varied and contradictory explanations for depression and different ways of treating depression. Depression is a personal and subjective experience which individuals try to make sense of in the context of their own lives, and it is important that this is acknowledged in treatment and more generally in communication about depression. Depression is a complex personal and subjective experience, and not an experience which can be neatly categorised.

APPENDIX A

Recruitment Notice for Study I

BELIEFS ABOUT DEPRESSION

Volunteers of all ages needed to take part in a study of beliefs about depression and emotions for a social psychology project.

Volunteers will be asked to participate in small discussion groups for about 45 minutes. Confidentiality and anonymity assured.

Please contact :-
Sian Lewis
Department of Psychology
Western Bank
Sheffield. S10 2TN

Tel. 768555 ext. 6543 or 6564
(Please leave a message with your telephone number if I'm not in).

APPENDIX B
THE METHODOLOGY IN PRACTICE: FURTHER DETAILS

This appendix is concerned with the practical process and development of the methodology of the thesis. Whereas in the main text the methodology is outlined with more emphasis on its conceptual development, here more details are given about the mechanics of developing the methodology. The process is outlined from the interview to the final research account presented in this thesis.

The interview

At the start of the interview I emphasised that the interview was confidential and that all identifiers would be changed. Participants were told that they could refuse to answer any questions, they were asked to indicate anything with which they felt uncomfortable, and they were requested to ask for a break if they needed one.

In order to minimise the power relationship involved, I also emphasised that I was interested in their accounts of their experiences and that I was not an expert nor looking for correct answers: in the case of the women interviewed in *Study IV*, I said that I had no children and that I was interested to hear about their experiences, and in interviews with patients for *Study II* I emphasised that I had no connection with either the hospital or the general practice.

At the end of the interview, I also ensured that participants had my telephone number in the psychology department in case they needed to contact me at a later date. I telephoned them a few days after the interview to thank them for taking part, to check that they did not feel uncomfortable about the interview, and to give them an opportunity to withdraw from the study if they wished to.

On four occasions I interviewed more than once in a day. On reflection this was not helpful. Interviewing itself was a fairly exhausting process and the quality of later interviews and my concentration may have suffered. This occurred particularly when interviewing for *Study III* and was due to the limited availability of participants' time.

Practical issues in interview technique and the interview relationship

The interview has been described as proceeding in three phases: warming up, the main body of the interview and winding down (see Chapter Two, Part I, Interview design). In practice the pattern of the interview also varied across participants: some participants started talking of their experiences of depression almost immediately, others talked about their feelings more gradually. In one case, I spent about fifty minutes with a woman

interviewed in *Study IV* as she tidied her kitchen and watered her garden, before the interview could begin. Some participants said that they had been thinking about what to say prior to the interview, others were clearly waiting for the questions I asked them. I achieved a better rapport more easily with some participants than with others. Interviews also developed along different patterns depending on participants' styles: some participants were clearly more used to articulating their experiences, for others this was a newer experience and their answers tended to be more factual and brief.

One issue which emerges from this, but which I have not pursued in this research, may be the development of *participants'* different interview styles and the emergence of different data. Some people are more articulate and more used to talking and reflecting on their experiences than others. During the processes of interviewing and analysis it became clear that while it is difficult to take account of what is not said, it is necessary to be aware of some participants' greater difficulty in talking about and reflecting upon their experiences. This in itself is particularly relevant in looking at how people do attempt to make sense of their experiences. (See for example the discussion of psychiatric out-patients' explanatory frameworks for their experiences of depression, Chapter Five, Part II, Part C).

I was struck, particularly when reading transcripts of interviews, by my shortcomings in achieving the neutrality which is traditionally associated with "good" interview technique. In particular I made a number of implicitly judgmental comments, for example, "that's awful", and, "you must have felt terrible". This was sometimes a problem of inexperience, and in particular I tended to speak too quickly to fill a silence rather than give participants a chance to think or speak, although at the same time I did not wish participants to feel obliged to fill silent periods, particularly if they were distressed. But at other times it simply did not seem appropriate to react neutrally to participants' accounts, when such neutral reactions might have been seen as negating the difficulties of their experiences. The interviewer is not neutral and does form a relationship with the research participant (Oakley, 1981a). For example, on at least one occasion I was asked by a participant if I saw her as "normal", which I certainly did, and on another I challenged a participant's self-critical account of herself, since to do otherwise might have been seen as confirming her negative image of herself, with which I disagreed. While I was not a therapist, the interview in this sense did constitute some form of intervention.

On three occasions participants asked me for my opinions on an issue. Offering these seemed to help rather than hinder the progress of the interview in generating useful discussions. I also found that where participants were not interested in my opinions they

simply ignored them anyway, and that it was better to wait to be asked for an opinion than offering one uninvited.

Tape recording interviews

Participants were aware of and to some extent, I believe, restricted by taping of the interviews. Participants occasionally made reference to the tape recorder in the interviews. Two participants commented that they were not going to talk about an issue while the tape recorder was on, and a third commented in jest, "Between you, me and the tape recorder". However, since this was a reminder that the interview was for research purposes, this awareness may have been ethically more appropriate.

In some ways the use of the tape recorder does restrict the interview, and participants were often more relaxed and forthcoming after the "interview" proper was over. Participants often made interesting comments after the tape recorder was turned off and the interview was over. On a couple of occasions I asked participants' permission to turn the tape recorder back on, and while on others I made notes after leaving them about issues they had raised these could not be included in the transcript. Participants may have quite strong expectations about what it is to "do" an interview and these may be constraining.

Equipment

Equipment needed to be of a high standard, and high quality tapes were essential for transcribing. Through my mistakes I learnt the importance of testing out the equipment and being aware of technical pitfalls while at the same time not becoming too distracted during the interview. The best tape recorder was a small personal recorder with a small microphone, which I placed near the participant. A tape recorder with two microphones, preferably lapel microphones, would have been ideal but was not available from the psychology department at the time. Initially I used a older model recorder but interviews taped using this (all interviews in *Study I* and seven interviews in *Study III*) were of poor quality: although I could hear them, having done the interview, a secretary for whom the data was unknown could not. (This problem was resolved by myself transcribing most of the poor quality tapes, and through the help of a transcriber who worked at home and was able to work in a very quiet environment with little interference.)

Practical problems with taping interviews were the need to position the microphone appropriately, testing how well it picked up participants' voices, and checking and changing the tape while disturbing the flow of the interview as little as possible. Although checking the tape and recording levels only meant leaning forward and glancing at the machine, this did mean a change in my attention which most participants noticed and

some commented upon. I tested the pick-up of the microphone if participants were relaxed but not if they appeared nervous or anxious, since I felt that this would not help put them at their ease. On one occasion, I switched on the pause button during a break and then forgot to switch it back off for five minutes after the interview resumed.

After the interview

On return after each interview, I checked that the tapes had recorded and were of an adequate quality (since if they had not I could at least have made more detailed notes about the interview).

I made notes immediately after each interview based on my immediate impressions: issues which struck me immediately, the process of interviewing, how the interview differed from or was similar to other interviews I had done, my interview technique and how I had felt doing the interview. These issues varied greatly between interviews, depending on the length, difficulty and immediate impact of the interview.

These notes were available for reference during the analysis, but in practice I remembered each interview clearly when analysing the transcript and did not refer to my notes very frequently. However, making these notes may also be seen as the first stage of analysis. I also thought about each interview for several days after doing it, and began to form ideas about it, although this was not necessarily formal analysis. Making notes immediately was also useful to some extent as a debriefing exercise for myself.

Confidentiality

After the interview, tapes were labelled with a code number for the participant and study, and with the date of the interview. A sheet with numbers and names was kept separately from the tapes to ensure confidentiality.

One difficulty regarding confidentiality was whether participants mentioned people by name. Initially I asked them to avoid using people's names, particularly the volunteers interviewed in *Study IV* and health professionals interviewed in *Study III*. However, participants inevitably did use people's names, and I decided that the best approach was to remove names at the transcription stage, since otherwise the flow of talk was interrupted.

Transcription

Transcripts were on average 12,000 words long (about 60 minutes of tape), with the longest (about 120 minutes of tape) about 19,600 words long and the shortest (about 15 minutes of tape) 2,250 words long. I transcribed 13 interviews in *Study I*. I also

transcribed 7 interviews in *Study III*, since the tapes were of poor quality. I transcribed these tapes by hand, although those in Study III were later copy typed. It took me six to eight hours to transcribe one hour of tape (this was by hand rather than typed).

Secretaries transcribed the rest of the tapes. They were asked to transcribe verbatim, and to indicate pauses with a dash (-) and sections they were unable to transcribe, where the recording was too poor, were shown by (...). I then checked the transcripts against the tapes, and changed all identifiers, names and place names. The confidentiality and anonymity of participants was emphasised to all transcribers and they were asked to stop transcribing if they recognised anyone's voice.

In all, six secretaries were involved in transcribing. This number was used because it was initially difficult to find someone with the time and facilities to get through a sufficient amount of work, although eventually I found one secretary who was working from home and did the bulk of the work. Secretaries also appeared to vary in how difficult they found the tape to hear, and fortunately the transcriber working at home was able to transcribe tapes others had found too difficult, probably because she was working in a quieter environment.

The average cost of transcription was £3.50 an hour, with a maximum of £4.95 per hour. It took the main transcriber three to four hours to transcribe one hour of tape (the time varied according to the quality of the recording, how much was said and how clearly participants spoke). The cost of transcribing was met by the Howard Morton Trust of the University of Sheffield. This was essential since without the help of transcribers it would have been impossible to use the same amount of data or number of participants.

Initially I transcribed using a tape recorder, but this was slow and clumsy to use. A transcribing machine enabled a faster speed of work and was needed for transcriptions whether typed or by hand. Using a transcribing machine the tape could be played back at varying speeds, the tapes were automatically backspaced when stopped and the tape could be operated by a foot pedal, improving the clarity of the recording and increasing speed of transcription.

Interviews were transcribed on to disc, and pragmatically this was vital for the data analysis and for producing research accounts, for which I used a Macintosh computer, since it avoided retyping the interview excerpts.

Data analysis

I developed the methodology through practice, rather than following a prescriptive methodology. Although I had read about qualitative methods, written descriptions of methodology often do not give sufficient details of the practicalities of the stages involved in actually analysing qualitative data. I was surprised by the complexity and difficulty of the process of analysis.

There was a limit on what could be achieved and retrospectively it has been important to recognise the validity of all approaches to the data, and the impossibility of achieving any waterproof analysis. However, in practice I experienced a number of what I thought at the time were "false starts", when I tried out different methods of analysing the data, and I frequently felt that I was getting nowhere and I rarely felt in control of the data.

It is difficult to say precisely how long analysis took, and writing up the thesis itself involved a further level of re-analysis. However, I spent on average about fifteen weeks analysing the data for each study, reading around the issues and wondering where to take it next. Much of this time was spent in achieving some confidence in and redeveloping themes I had partially identified, through re-analysis of the data. Analysis was a recursive process, as I developed different approaches through the studies and returned to earlier work to take a different approach. I often felt that I was jettisoning earlier work which I thought might be inadequate, and I felt a tension between the desire to start again and the need to build on earlier work.

A major issue for each study was whether to analyse on a case study basis or across transcripts. I felt that in order to get a feel for and "understand" each transcript analysis had to be on a case study basis, at least initially. In practice I made detailed notes on selected transcripts, selected on the basis of those who gave a more articulate and fuller interview, and then identified themes recurring within other transcripts. But in practice this was a difficult task and I prevaricated between case studies and across interview analysis. There were also too many interviews to be able to analyse all effectively on a case study basis, and I was aware of common themes between interviews. The real difficulty was how to construct an across interview analysis without loosing the complete picture in each interview. I decided that in order to construct an across interview analysis, which would also be true to meanings as constructed within individuals' interviews, a within interview analysis was an essential first step. This was also frustrating as it later meant losing much work, which had been done at an individual level, in the final research account.

Analysis was a confusing process, and issues which arose through the practice are discussed below:

"Learning" the data

In retrospect all approaches I used appear to have contributed to my familiarity with the data, which was critical in the process of analysis. One major issue was that analysis depended on knowing the transcripts well, through reading and rereading the transcripts. Although I often felt I was not making progress, but almost learning the transcript, and absorbing its contents rather than constructing an analysis, it was critical that I had a good knowledge of the data without referring to transcripts, since the analysis depended on my thoughts and reflections on the data.

Analysis began with reading the transcript and underlining key phrases or points. I made notes on the transcript copy itself (see following page for an example) or on a separate sheet, referenced by page number, on longer excerpts and phrases which seemed particularly meaningful. This also meant identifying apparently contradictory sections. I initially read all the transcripts in the study and then began to identify possible themes on the basis of this. I then reread transcripts and attempted to immerse myself in the data. This was time consuming and frustrating and confusing. Although I became increasingly aware of points of interest in the data, it was difficult to formulate these into themes or "results". It became increasingly difficult to distance myself from the data as I achieved greater familiarity with it.

long time to, like, forgive, you know, to not feel that's what, you know, to try and understand their point of view why they couldn't or why they didn't. Erm, but that was er, I didn't like it, I felt like I didn't have one person who I could just sit and talk to. Because I was having loads of problems with their Dad, you know, he was useless, I mean, a lot of men a totally useless in that emotional way. You know, I mean, me and my Dad talk quite a lot more now. Er, but he would never talk to anybody about, he'll talk to me more than he will his girlfriend - my Mum and Dad have split up now - he'll talk to me more than he will his girlfriend.

Sense of being lost. Reflection on her position at time they seem to have power to help. 3

Yes.

Or anybody else really but I suppose they're not really taught, less than women they're taught not to let, you know, cry or let things out, you know, so theirs comes out a lot of the time as violence or point the, you know, sometimes people point their finger at other people don't they, if they're feeling depressed and things.

Again Childhood - taught to repress.

Aggression as depression. 7

Yes.

They take that responsibility 'cos you still, at the end of the day, you can't blame people for how you feel. You know, like if you're feeling depressed you can't like point your finger and say, "That's your fault or your fault", which is - . In some ways I suppose I did do that with my Mum, you know?

Personal responsibility

Yes.

Focusing down

The volume of data was a major concern. The need to know the interview transcripts well in effect limited the number of transcripts I could deal with in detail at any time. Some interview transcripts were more illuminating than others: where people had been more reflective, more articulate and more expressive. These transcripts often became a focus of analysis and one issue was the extent to which each case could have provided a sufficient analysis in itself, and the extent to which particular transcripts influenced my interpretation of the body of data as a whole.

The tendency to concentrate on some transcripts rather than others also had important implications in terms of selectivity of data. However I attempted to validate themes throughout transcripts. Although not all themes appeared in all transcripts, I developed in the research account those themes which appeared most "powerful" throughout accounts. This was a subjective judgement, though based on knowledge of the transcripts, and one anxiety was the selectivity of themes. "Powerful" themes were those which were most useful in interpreting the data and making sense of participants' accounts of their experiences, and which elucidated the data. Some transcripts were more productive of such themes than others, but themes were developed throughout all the transcripts i.e. a theme might initially be developed from one transcript but was only further developed if it elucidated data in other transcripts. Thus while some transcripts might produce more themes than others, these themes were important in shedding light on to the data base as a whole.

Inevitably interviews with some participants did provide fuller accounts of their experiences of depression and did attempt to explain these in greater depth. Through the process of analysis, I became aware of an important distinction between "interpreting" and "explaining" the data. While I was aiming to interpret the data, I also found myself often attempting to explain it, in terms of looking for "causes" for the accounts individual participants gave, for their experiences and for the ways in which they interpreted them. At these times I felt that I was trying to "stretch" the data, as I attempted to move too far beyond it and to make conclusions for which I had little evidence, or to fit the data into neat explanations or models as I sought to explain it somewhat "objectively" (see also Chapter Ten, Part III, Part C, section 1). It was important to remain focused upon and grounded in participants' accounts, and attempt to interpret their accounts from their perspective, rather than to try to explain their accounts. Some participants were more articulate and gave a fuller accounts of their own experiences and perspectives, and themes in their accounts were often useful in interpreting or making sense of the accounts of other participants. In this sense, analysis sought to both draw upon and do justice to

the perspective of participants and to be aware of and provide an interpretative account of their perspectives.

Trying to achieve some clarity

One effective method of analysis was the use of a Macintosh computer to create files on emergent themes (see also Morse, 1991). All the transcripts in *Studies II, III and IV* were on disc and it was possible to work through a transcript and copy and paste excerpts into files which formed the basis of themes. I then printed out the files and made further notes, sometimes merging and redefining themes. Themes were not clearly distinguished and did overlap. Another problem was identifying themes within an interview while retaining some sense of the integrity of the interview, and this was resolved by identifying links between themes. Thus for some interviews I wrote initial case studies based around and linking themes. At this stage it became clear that some interviews produced more themes or clearer themes than others. It also became clear that themes identified in one interview were not the same as those in another, and that another level of analysis was needed in order to build up links between interviews.

Beginning to write a research account

I wrote some analyses up as analyses of individual interviews, in *Study I* and *Study IV*, but this was clearly inadequate to deal with the bulk of the data. Rather than continue with this approach through all interviews I attempted to stand back from the data and look for common themes without doing an individual case study on each interview. Having made extensive notes on interviews, the task of drawing the notes together into an analytical accounts was daunting. One approach I used was to write an account based around a theme which appeared dominant throughout interviews and link other themes to this theme. This meant rereading notes on interviews, constructing an account with reference to the notes, and also rereading sections of the interviews and extracting excerpts to illustrate themes and accounts from the data base. At this point I would usually notice additional points or alternative interpretations of the excerpts which led to a different angle in the research account.

In practice I wrote and rewrote research accounts, attempting to construct a coherent story or interpretation. This was often extremely frustrating and stressful, and it was difficult to identify ways of making sense of the data which did justice to its complexity. It was at times difficult to live with this degree of uncertainty.

Gaining perspective

I found that talking to people who did not have knowledge of the data was useful in generating interpretations, and sometimes enabled me to step back from the data and take a broader view. This occurred in seminar groups and supervisions, as well as in less formal settings. Overall the analysis tended to "crystallise" through my increasing familiarity with the data and with the literature, and through talking about my research with people who were not directly involved, including for example a friend who had been depressed after the birth of her children. She confirmed the themes I had identified in her own account (not part of the data base) of her experiences and her reflections of motherhood.

For example, before I began my research for *Study III* (interviews with health professionals involved in treating depression), two academics who were not involved with the project had mentioned the importance of organisational factors for health professionals working in this area. This was also suggested by one participant in an interview. But I put this to the back of my mind and it was not an issue I identified as important until I had read all the transcripts and identified initial themes, which reminded me of my notes on these conversations.

In *Study IV* (interviews with women about their experiences of depression and motherhood) after weeks of struggling to write some sort of coherent research account and looking for linked themes within the data, while struggling with the multiplicity of themes which did not seem to present any coherent story or way of understanding or interpreting accounts, the analysis suddenly became clearer when I began to think of accounts in terms of loss of identity, and this provided a way of understanding the experiences which women were themselves talking about. Ironically one participant had already described motherhood as a loss of identity, but I had not understood women's accounts in terms of this. This strand of analysis then developed as I looked at how women experienced a loss of self or failed to define themselves within relationships, and how the sense of self became lost as a woman was identified by others as a mother. Analysis in terms of loss of identity or of self incorporated themes such as powerlessness, the availability of alternative identities and the importance of motherhood to sense of self, and reinforced the earlier theme of the experience of depression as a loss of self.

Writing the final account

The research account presented in this thesis was drafted after I had read all the notes and reports I had written earlier. Inevitably later work, since it was based on earlier work, was more useful although I drew something from all earlier work. Writing the final

research account was a difficult task, since it meant deciding how to combine various approaches, and what could be omitted and what could be incorporated into the research account.

Working on successive drafts and using feedback from supervisors and colleagues was useful in that it enabled a more coherent account to be produced and new perspectives on the data could be developed. Now a major problem was knowing when to draw the process to a close (see Chapter Ten, Part III, Part C, section 1). This was in part a pragmatic consideration and in part determined by my own feeling that, at least at that time, I had provided as clear as possible an interpretation and to some extent had "exhausted" the data. While I was aware that other interpretations could be made, I was satisfied that what I presented was a valid interpretation which presented what I saw as major issues in the research and moved some way towards answering the research questions.

Summary and concluding points

This appendix has attempted to show some of the practical issues in using a qualitative methodology as developed in this thesis. It has been emphasised that qualitative research is difficult and confusing, and that there are no clear answers as to how to do it. The advantages of qualitative research, the richness and complexity of the data, form both part of the pragmatic problem in dealing with it and also, for me, the motivation to pursue it.

While I was not claiming that my interpretation of data was the most valid one, I did endeavour to provide an account which as truly as possible reflected the participants' concerns. I had not considered that it would be ethically appropriate to take interpretations back to participants since this might be challenging to them. I was not a therapist nor counsellor and felt unable to provide appropriate support for any problems which might have arisen. It might have been useful to have compared my analysis of transcripts with the analyses of other researchers, but no other suitable researchers had time to do an adequate analysis.

I have presented data which illustrate themes and form the basis for the research account. However, I have made no claims that other themes could not have been identified. I have identified, through a thorough analysis of the data, those themes which enabled me to make sense of that data.

APPENDIX C

Interview Guide for Patients, Study II

Personal details:

Name, age, married/ single/ cohabiting, number of children if any, occupation.

Self, identity and relationships:

How you would describe yourself?
What have been your happiest and saddest times, events and occasions?
How you would describe them?

What are the important relationships in your life at the present time?
Have these relationships changed recently?

What is your daily routine? (follow-up: pleasures and problems, any time spent alone).
How do you feel when you wake up in the morning?
Are there any changes you would like to make in your daily routine?

What do you expect of life in the future?
Are there any improvements and changes you would like to make in your life in the future, or in yourself?

Emotional experiences:

Can you describe any times when you have been particularly happy or upset: for example, what happened, how you felt.

How easy is it to talk to other people about emotional times?
Are there times when other people have talked to you about difficult periods in their lives?

Who would you go to for help if distressed?
Who have you gone to for help if distressed?
Have you ever gone to your GP, or any other health professional, for help when distressed? When, why, and has it helped?

Continued

APPENDIX C

Interview Guide for Patients, Study II, continued

Experiences of depression:

Any definitions of depression you can think of.

Have you ever known anybody whom you would describe as depressed?
Would you say you have ever felt depressed? How would you describe depression, how did you feel?
Do you think anybody else has described you as depressed?
Do you think you could ever have been medically diagnosed as depressed? What would this mean to you?

Is there anything that we haven't covered in the interview that you would like to add?
How you have felt doing this interview? Do you have any comments about it?

APPENDIX D

Interview Guide for Health Professionals, Study III

Personal details:

Name, age, time spent in occupation/training.

Depression:

Do you think there is such a thing as "depression"?

If so: how you would define "depression"?

is "depression" a useful term?

How would you describe the experience of depression? For example, in terms of thoughts, feelings, behaviour.

What are your ideas about possible causes of depression?

How widespread a problem is depression?

How difficult is it to treat depression?

When should people be referred for treatment for depression?

What is the significance of a medical diagnosis of depression?

What do people mean when they say they're "feeling depressed"?

Assessing depression:

How easy is it to talk to clients/patients about depression? How do you set about talking to clients/patients? What do you achieve in talking with clients/patients? What is difficult or dissatisfying?

How do you stop yourself becoming over involved with your clients'/patients' problems?

Are there any ways in which you think your assessments are idiosyncratic, and why?

How useful is experience in understanding clients? -what experiences and why are they useful?

What is your approach to treatment for depression?

Professional role:

How would you characterise your work and your profession? (For example, skills, aims, constraints on practice).

Why you want to work with this group of people (your clients/patients)?

How did you become involved in this sort of work?

What do you think are your relevant personal skills or experiences?

Continued

APPENDIX D

Interview Schedule for Health Professionals, Study III, continued

Professional role (continued):

How would you describe your actual relationship with your patients/clients?
How would you describe your ideal relationship with your patients/clients?
What changes, which would reduce the problem of depression, would you like to see in an "ideal world"?

Is there anything that we haven't covered in the interview that you would like to add?
Do you have any feedback on the interview?

APPENDIX E

Interview Guide for Mothers, Study IV

Personal details:

Name, age, married/ single/ cohabiting, number of children if any, occupation.

Involvement with the voluntary organisation:

How did you get involved with [volunteer organisation]? Who referred you and why?
How does [the organisation] help you? - any benefits? - any problems?
Is it different to other forms of help you've received?

Motherhood:

What did you do before the birth of your child(ren)?
What was your experience of pregnancy like?
What changed in your life after the birth of your child(ren)?
What is your daily routine now?
What do you enjoy about motherhood now? What are the problems?

Self, roles and relationships:

What are your important relationships? With whom? Why are they important?
Have your relationships, for example with your friends and your family, changed since having children (including any changed or new relationships)?

Do you think other people see you differently now, compared with before the birth of your children?
Do you think you changed since having children, and in what ways?

Do you have important roles or activities other than motherhood? How important are these to you and why?

Experiences of depression:

Have you ever felt depressed?
If so, when, why, for how long?
If so, how would you describe depression?
Do you currently feel depressed or down sometimes?

Continued

APPENDIX E

Interview Guide for Mothers, Study IV, continued

Experiences of depression (continued):

Can you talk about depression? Who to?

How easy is it to talk about depression?

How would you explain depression to someone who hadn't experienced it?

Have you been to anyone for help with depression? Who and why? Did it help?

How do you see things changing in the future, if at all?

Is there anything that we haven't covered in the interview that you would like to add?

How you have felt doing this interview, any comments?

APPENDIX F

Interview Guide for Volunteers, Study IV

Personal details:

Name, age, married/ single/ cohabiting, number of children if any, occupation.

Involvement as a volunteer:

How did you become involved as a volunteer?

How would you describe your aims in your work?

What do you get out of this voluntary work (any positive and negative aspects, pleasures, stresses, frustrations)?

Is this voluntary work different to things you've done before?

Training for and experience of volunteer work:

What did you learn in the training that was useful?

Why are "your" mothers visited? What problems do they have?

What do you do in visits? How much do you think this helps the mother, and how?

How would you describe your relationship with the mothers you visit?

Are other sources of help available to them?

Depression:

Is the mother you visit depressed? How do you know? Why?

If so, do you talk about her experiences of depression?

How easy is it to talk about depression?

What do you think depression is?- definition, description, own experience, any reading or training about depression.

What do you think is the best form of help for depression? - for mothers/ people in general? (Follow up: How useful is medical help?)

How widespread do you think depression is among women/ mothers/ people in general?

Participant's own experiences of depression:

Have you ever felt depressed?

How would you describe feeling depressed?

For how long were you depressed?

Do you have any idea why you were depressed?

Have you any experience of depression (in others) other than through your volunteer work? for example, among your family and friends?

Continued

APPENDIX F

Interview Guide for Volunteers, Study IV continued

Participant's own experiences of motherhood:

Could you talk about your own experience of motherhood. For example, what did you enjoy? did you have any problems? was it what you expected? did you have any sources of help?

(Follow-up: Any ideas about preparation for motherhood, about good and bad mothering, about important sources of help in motherhood for self or for mothers now visiting.)

How do your own experiences of motherhood and/ or depression help you in your volunteer work?

Has your volunteer work changed since you started?

Have you or your views changed since starting this volunteer work?

Is there anything that we haven't covered in the interview that you would like to add?

How you have felt doing this interview? Do you have any comments?

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