SOCIAL CONTEXTS OF DEPRESSION

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ABSTRACT

This thesis documents the meaning of depression for 80 people living in the inner Western suburbs of Sydney in the late 1980's. It also documents the views of 20 general practitioners who practised in those suburbs.

Accounts of depression have always been controversial. Different disciplines put forward varied explanations and prescriptions about treatment. Despite the apparent proliferation of research into the area of depression, limited attention has been given to the social context of depressed respondents' lives. In this Sydney study, however, a combination of clinical and social criteria were used to make sense of the 80 respondents' experience of depression.

The meaning of social context and the notion, 'impaired social functioning', were analysed in terms of a mixture of respondents' positive and negative experiences at work, in relationships and with reference to social conditions. For all 80 respondents, role performance was impaired in at least one area. The label 'no relief in sight' describes those respondents who felt that work, relationships and social conditions contributed to their depression. The notion 'highly vulnerable' draws together the experiences of 43 (54%) whose role performance was impaired in two out of three areas. The term 'not so vulnerable' identifies the 31 (39%) who had been functioning, in their terms, 'below par', or 'at a low ebb' in one specific area.

General practitioners' views of depression and of the conditions which affected their ability to treat depressed people were examined. These doctors' adherence to a view of their practice as a scientific endeavour, and the fee-for-service arrangement for paying doctors discouraged them from considering social issues.

From the 80 respondents' perspective, issues raised about treatment, both medical and non-medical, ranged from apparent willingness to seek medical help to reluctance to do so and a reliance on self-remedies. Respondents' accounts of non-medical treatment ranged from confiding in one key person to collective social endeavours, from physical activities to self-medication. Although respondents' experiences of depression were rooted in the constraints of context, their remedies were individualised attempts to help them 'feel better'. Social problems were as difficult for respondents to remedy, - hence the reliance on individual solutions, as they were for doctors to discuss, let alone treat.

The non-medical professionals' response, as identified by these respondents, was also of the 'quick fix' nature. Individuals were regarded as responsible for their condition, a point of view which did not match the respondents' experiences of depression. They explained depression as a response not only to personal difficulties but also to the consequences of what they saw as debilitating social and economic policies.

In any future deliberations about the nature of depression, it would be helpful to conceptualise 'treatment' in terms of an educational experience. The reconstruction of that experience would produce a contrast to individualised remedies and a real alternative to traditional forms of medical intervention.

ACKNOWLEDGMENTS

This research depended on the participation of the respondents who kindly agreed to be interviewed and who were generous with their time. Without their cooperation and frankness, this research could not have been conducted. In an attempt to disguise the identity of participants, pseudonyms have been used. Many of these individual respondents' observations, however, have been used verbatim.

The advise and support of Professor Charles Bridges-Webb and Dr Brian Driver, of the Department of Community Medicine at Sydney University, were indispensable.

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PART I

CONFRONTING THE ISSUES

CHAPTER 1

THE CONTENTIOUS NATURE OF DEPRESSION

A Common Yet Enigmatic Condition

A common word and a common experience, depression represents a widespread mental health problem: between 8% to 15% of a population are likely to suffer from significant depression at some time during their life (Fraser, 1947; Shepherd et al. 1959, 1966; Rawnsley and Loudon, 1962; Locke and Gardner, 1966; Fink et al. 1970; Goldberg and Blackwell, 1970; Susser et al. 1970; Weissman et al. 1978; Harding et al. 1980; Parker et al. 1984; Beaumont, 1986). Depression has also been called the world's number one public health problem, the 'common cold' of psychiatric disturbances. It has attracted much attention from researchers whose findings include different definitions and ideas about the possible causes of depression and conditions associated with it.

The word 'depression' connotes a range of thoughts, feelings and illnesses. The term is confusing. In certain cases it refers to a mood state. In others it describes a symptom or a syndrome (Figure 1.1). No single model covers all the current knowledge of depression. None of the explanations of depression is necessarily exclusive of others. However, commitments to foster one school of thought rather than another make it difficult to group the exact connotations of depression let alone the social contexts associated with such a condition.

In addition to the controversies between schools of thought, or which may be the same thing, professional disciplines, there are difficulties within the particular schools or professions. One of these difficulties concerns the conundrum whether causes or associations, explanations or consequences are being discussed. That is to say, an association which exists between A and B, does not necessarily mean that A caused B, or that B caused A. Some events may be causes, others consequences.

Figure 1.1: Depression: A Continuum

Symptom			Syndrome
Sadness			'Endogenous'
'Feeling down', 'low' etc.	Grief Normal	'Reactive' 'Neurotic'	'Psychotic'
Some dysfunction but not incapacitating			Dysfunction and incapacitating
Short duration			Prolonged duration

There is no reason to believe that all forms of depression have the same cause. It is also important for researchers to define the kind of depression they are investigating and to be clear and explicit about the criteria they are using in their analyses. (This allows results to be compared with those of others who studied the same type of depression, and also indicates the relevance of results for particular people). As a researcher I was concerned with the social contexts of depression, I wanted to know what had already been said about that issue. To answer that question I had to find a way through the claims of different theorists and practitioners.

As part of this 'finding a way', I divided my enquiry into three broad areas: the first deals with 'physical' or 'biological' explanations of depression, the psychiatric perspective, the second with psychological explanations and the third with social explanations.

Psychiatric Controversies

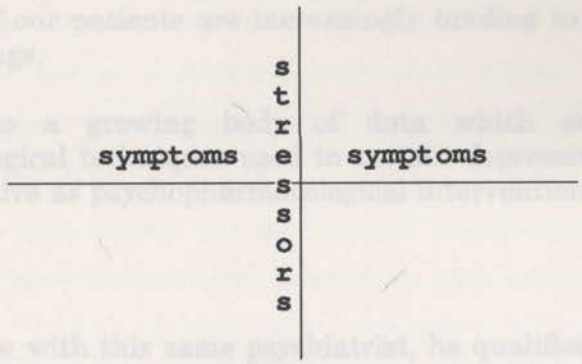
There has been great controversy, particularly in the last twenty years within psychiatry, as to the classification of depression. Many different

classifications of depressive 'illness' have been proposed and disputes between the protagonists of rival schools still smoulder.

A detailed review of these conflicting claims and proposals is beyond the scope of this work, so I shall confine myself to the principal features of psychiatric perspectives on depression. The current trend is to unify the concept of depression into a single entity having its own characteristics and appearing clinically in varying degrees of severity. Another school of thought questions whether the various forms of depression are best understood as being one illness which shows itself in different ways, or as being different illnesses. The distinction most often used in medical circles, is between neurotic versus psychotic and reactive versus endogenous depression. The neurotically depressed person would be depressed, but in touch with reality, while the psychotically depressed person would allegedly not be in touch with reality. Reactive means that the doctor thinks the patient is 'reacting' to some recent event and believes this to be the immediate cause of the depression. Endogenous, on the other hand, means that there appears to be no immediate cause which by itself would account for the patient's depression. Another label which is sometimes used is 'clinical depression', meaning depression serious enough for medical treatment.

Yet another explanatory model views the 'type' of depression as being an interaction between symptoms and stressors. That is, the vertical 'stressor' axis runs from 'reactive' to 'endogenous' while the horizontal 'symptoms' axis runs from 'psychotic' to 'neurotic' (Figure 1.2). At the heart of these explanations rests a confusion of semantics. It has often been pointed out that 'neurotic' and 'psychotic' are incapable of precise definition and usually mean little more than 'mild' and 'severe'. Similar problems of definition and logic are raised by 'endogenous' or 'exogenous' (Lewis, 1934; Kiloh and Garside, 1963; Kendall, 1968).

Figure 1.2: Interaction between symptoms and stressors



Some theorists have regarded 'psychotic' and 'endogenous' as synonymous, and 'neurotic' and 'reactive' likewise, using either pair of terms to denote two contrasting syndromes. Other authors have interpreted the terms more narrowly and more literally: confining the term 'psychotic' to illnesses characterised by delusions, hallucinations or gross loss of insight, the term 'reactive' to illnesses preceded by obviously stressful events, and the term 'endogenous' to illnesses lacking such precursors. For those psychiatrists who insist on these definitions, a depressive illness could be reactive without necessarily being neurotic or be called psychotic without being endogenous, or vice versa. But for the psychiatrists who do merge the descriptions into one another, such distinctions would be meaningless. These differences have produced many misunderstandings and sustained many disputes.

In order to obtain some first hand accounts of those issues, I interviewed five psychiatrists (and 20 general practitioners) about their explanations of depression. In the case of the five psychiatrists whom I spoke to, before gathering other research data, I was struck by their certainty and confidence. They promoted their explanations as though they had discovered an accurate explanation and appropriate treatment. In retrospect though, I have to make sense of the doubts which somehow seemed inherent in their certainty.

Recently, an Australian psychiatrist wrote:

1. Most types of depression do not require anti-depressant medication.

2. Many of our patients are increasingly tending to question the use of such drugs.

3. There is a growing body of data which suggests that some psychological techniques used in certain depressive disorders may be as effective as psychopharmacological intervention.

(Goldney, 1986)

In my interview with this same psychiatrist, he qualified these assumptions about the treatment of depression but still made no direct reference to the social context of patients' lives:

> Of course, it is true that psychiatrists probably see the most severe and long-term cases of depression. For a lot of cases we see, drug therapy, ECT and very rarely, even psychosurgery are the most effective form of treatment. I have seen cases where one or a combination of these forms of treatment have led to an immeasurable improvement in life-style.

(Interview, Feb. 1988)

Such comments raise the difficult issue of whether depression is really an 'illness'. The psychiatric perspective, often referred to as the 'medical model', looks at depression as being like a physical illness. It has certain definite symptoms which can be cured by drugs or other forms of 'physical' treatment. At its simplest, this model assumes that a depressed mood is caused by the physical disturbance in the body. But this claim also introduces a classic chicken-and-egg puzzle: it can equally well be argued that the physical symptoms are the effect of the depressed mood.

Although physical symptoms are part of the experience of depression, from a psychiatric perspective, depression has a physical cause. This approach to depression implies that the physical cause should be eliminated as soon as possible. 'Chemical cures' are most frequently prescribed. The terminology used accentuates certain ideas of abnormality. Depression as a psychiatric 'disorder' implies that the normal healthy mind is always an ordered one. It suggests that if you are depressed, something inside you is 'out of order'. The notion of something

'inside' suggests the possibility of something 'outside' i.e. concerning social context, but this issue seems to merit scant attention.

It is now some twenty years since it was proposed that some forms of depression may be caused by a chemical imbalance in some part of the brain's biochemistry. Evidence in favour of this hypothesis is becoming stronger (Charney, Menkes and Henniger, 1981; Calloway, 1982). This still poses a dilemma. What is it that causes this biochemical disturbance in the first place? The people who have been studied have been those with a strong family history of depression.

That depression may be inherited is one of the major pieces of evidence to favour a biological component as the explanation of causation (Reverley and Murray, 1980). Although the pattern of its transmission from one generation to the next fits with it being an inherited disorder, the same pattern may be explained in other ways. For instance, being brought up by a depressed parent may have a considerable effect on a child. The family environment may play an important role in the 'handing down' of depression from parents to children. Can the influences of 'nature' and 'nurture' be distinguished?

Evidence of a genetic component in depression comes from two sources, studies of twins and studies of people who have been adopted (Depue and Evans, 1981). Such studies indicate that the genetic influence is strongest when people who have 'psychotic' depression are compared to those with 'neurotic' depression. The nature of the genetic link remains controversial.

In my own enquiry into the meaning of depression from the point of view of people suffering from that condition, I also wanted to know about treatment. That seemed to be as much part of the context of depression as the events which may have contributed to the condition. So I asked the psychiatrists about the links between their explanations of depression and their decisions about treatment.

(a) Chemical cures

Some general practitioners and most psychiatrists (see Chapter 10) prescribe drugs called anti-depressants. All the psychiatrists whom I interviewed commented on the 'remarkable' and 'swift' improvement of some patients for whom they had prescribed anti-depressants. The act of prescribing medication reflects thinking in terms of 'illness' and bodily symptoms.

What this perspective overlooks is that minds and bodies are not separate: physical and mental states interact. Some people are more likely to notice physical changes in themselves while others are more likely to notice emotional or mental changes. I shall address this issue in my subsequent description of depression as represented by the notion, 'impaired social functioning' (Chapter 6).

One characteristic of a psychiatric explanation is that it depends on experts to sustain it. Medication can be used oppressively. Taking medication alone, however, does encourage the patient to remain the helpless victim of fate, always needing an 'expert' to intervene. One woman whom I interviewed said she had learned to collude with the experts:

> My husband got jack of my depression and told me to go to the doctor. He kept saying "Why don't you go and get something to make you feel better"? So I went and the doctor gave me tablets. I think it's a way of keeping me quiet. I just accepted it.

For many years, doctors, general practitioners and psychiatrists, have been publicly criticised for their alleged over-prescription of anti-depressants. Yet many doctors, and each psychiatrist whom I interviewed had a 'success story' or two when it came to the benefits of chemical cures. These usually follow a formula: successful businessman or woman becomes severely depressed for no obvious ('good') reason; the depression lingers and interferes with their work (sometimes there is a suggestion of suicide) and the preferred form of treatment is drug therapy. The rationale for intervention in such cases is that drug treatment is more effective, faster-acting, less expensive and less intrusive than 'any form of counselling or therapy'.

Another form of medical treatment mentioned by some general practitioners and all psychiatrists whom I interviewed is ECT or electroconvulsive therapy. I was informed that currently the main role of ECT is in the treatment of patients who have failed to respond to an 'adequate course' of an anti-depressant drug.

(b) **Suspicions, fears and 'shock treatment'.**

Such is the efficacy of ECT, or rather, some psychiatrists' faith in this form of treatment that one psychiatrist insisted:

> I'd like my family and colleagues to know that should I become severely depressed, ECT would be my first treatment of choice.

In the 1930's it was discovered that artificially induced fits helped to lift severe depression in some patients. This is now achieved by passing an electric current through the brain, -- ECT or electro-convulsive therapy. It is used by psychiatrists to treat patients whom they describe as 'severely depressed' and who have not responded to drug treatment. ECT has also been used as an adjunct to drugs.

Although many psychiatrists consider it to be almost a 'magic cure', it has its disadvantages. It has been said to help many severely depressed people lead 'normal lives' again. It does however, cause memory loss, which is usually recovered after the last treatment. When people complain of continuing memory loss it is thought that it is the continuing depression or anxiety that is producing the trouble and not the treatment. This point is debatable.

Whatever the merits of ECT, it seemed difficult for the psychiatrists, particularly those who said they saw the beneficial effects of ECT every week, to understand the widespread apprehension and suspicion which such treatment arouses in other people. Cerletti, one of the pioneers of this form of treatment, was always aware of this. He explained:

> The idea of submitting man (sic) to convulsive electric discharges was considered utopian, barbaric and dangerous: in everyone's mind was the spectre of the electric chair (Cerletti, 1956)

Several psychiatrists told me of some patients' suspicions and fears regarding ECT. They said, however, that these concerns are voiced far more by the patients' relatives than by patients. This is hardly surprising given that the patient, prior to any experience of the treatment is probably too depressed and feeling 'powerless' to object to a course of 'only six treatments' as recommended by an influential expert, and sometimes confirmed by a Mental Health Review Tribunal.

While ECT remains a controversial, and some would argue dangerous form of treatment to which, in many countries constraining legislation applies, an even more permanent and frightening treatment exists. If ECT has been seen as a treatment that has sometimes been used as a convenient means of subduing 'difficult' patients, then the 'treatment of last resort' would undoubtedly attract the same criticism.

(c) 'A treatment of last resort'

This heading repeats the words used by one psychiatrist when describing the option of leucotomy or lobotomy. This psychiatrist was quick to point out that this form of treatment is now very rarely recommended by psychiatrists. He also stressed that the operation is a last resort, adopted only 'after years of treatment to which there has been no response'.

Of concern is the fact that the results of leucotomy are irreversible. With modern modifications of the technique, far less alteration of the personality now occurs. Nevertheless, it remains a drastic form of treatment, the seriousness of which is acknowledged by the careful assessment procedure. In Australia, three psychiatrists must make independent recommendations to a panel of five who review the evidence and make a decision. I was told that persons selected for leucotomy are meticulously investigated both as regards their own physical health, the results of all other feasible forms of treatment, and their home and family background.

Despite these assurances, the powerlessness of these patients indicates the potential for abuse. This form of treatment is, in potential at least, the ultimate example of the 'expert' directing the passive patient towards a form of treatment in which the patient has little or no say, and no willing participation. This form of treatment is 'surgical' rather than 'medical' and the depressed person is not required to take any responsibility for his/her treatment. Responsibility has been totally removed, except perhaps in the tacit compliance of the patient concerned.

Psychiatric conclusions

As yet, research has produced no hard-and-fast conclusions about depression and bio-chemical changes in the brain. This does not prevent some doctors from emphasising such causes. Perhaps the most controversial statement I heard from a psychiatrist was:

> True depression may be said to be only experienced by people who suffer from bio-chemical changes in the brain, that is, endogenous depression. Everyone else who claims to be depressed is just unhappy.

Many of the medical and psychiatric perspectives on depression assume a certain biochemistry. In consequence, the forms of treatment offered aim to address this biological chemistry. The principal forms of treatment, that is, drug therapy, ECT and less frequently, leucotomy, are all 'active' forms of treatment by an expert. Something is done to the depressed person, who remains the passive recipient of the expert's treatment. It is not only in this theory of depression, but also in the practice of being directive and active that psychiatric perspectives differ from psychological ones.

Psychological uncertainties

Although there are significant differences between psychiatric and psychological perspectives, psychology and psychotherapy have been used to keep 'patients in their place'. The characteristics which psychological explanations share with psychiatric schools of thought are the following. First, there has been an emphasis on the expert role. Usually the expert has encouraged the depressed person to adjust to their existing roles rather than to question them. Secondly,

these psychological perspectives have offered individual models of explanation of the depressed 'behaviour'. Consequently, the depressed person has been 'individualised' in his or her 'problems'. Thirdly, social psychology and popular psychology have confined their questioning to individual issues rather than social ones.

Within the psychological perspective there are many different schools of thought and orientations to treatment. However, whether the terminology is about rewards or cognitions, the expert's opinion is of paramount importance.

(a) Reinforcements and rewards

The behavioural approach within psychology views depression as being due to lack of enough rewards or 'reinforcement' for people's actions. Of the behavioural models of depression, 'learned helplessness', a concept based on work with animals, is probably the best known. For example, a dog is subjected to repeated unpleasant stimuli (like shocks) while at the same time being restrained (in a harness, for example) from taking action to avoid the stimuli. When the dog is unharnessed and given the opportunity to evade the unpleasant stimuli, it nevertheless remains still and continues to suffer them. It can be reversed by moving the animal away from the unpleasant stimulus. Researchers have suggested that this situation parallels depression in humans, because, in both cases, the individuals feel they have lost their usual control over their environment and therefore feels 'hopeless' and 'helpless' (Abramson, Seligman and Teasdale, 1978).

As its name suggests, behaviour therapy focuses on suggestions for changing the way people conduct their lives. In treatment terms, behaviour therapy encourages the depressed person to look at how they can structure their life differently in order to make it more likely that they will feel rewarded for what they do. The therapist would encourage the client to set goals of their own and help structure the stages towards achieving such goals, with ways of rewarding themselves as they go along.

(b) **Thoughts and attitudes**

Although the concept of learned helplessness sounds plausible and has attracted much attention, its relevance to depression remains questionable. It does not consider issues such as physical and social environment and the influence of significant other people in the depressed person's life.

By contrast, the cognitive theory of depression appears to include some consideration of social issues. Aaron Beck's name is most widely associated with the cognitive theory of depression. Unlike the learned helplessness model which originated from observations on experiments with animals, Beck's (1967, 1976) work with depressed people led him to formulate his theory about cognition.

The theory claims that depression is caused by certain thoughts, attitudes and ways of viewing the world. The term cognition describes a person's thoughts and the ways they are dealt with by the mind. Cognition includes beliefs, interpretations, expectations. Such cognitions form a link between experiences and people's emotional reactions to them. People use cognitions to interpret their immediate experiences. Between each external event and a person's emotional response to it, there is a thought, an interpretation, a making sense of the world in one way rather than another.

Through past experience, each person builds up a particular cognitive 'style', an individual repertoire of thoughts and ways of dealing with them. Cognitive theory holds that depression is associated with a group of maladaptive or unhelpful thoughts, which lead to what Beck has called the 'negative cognitive triad' made up of a negative view of oneself, of the world and of the future. In depression, cognitions become negative and distorted. Depressed persons are not aware of this happening because like everyone else, they take for granted that their automatic thoughts are true. One component of cognitive therapy involves training the individual to become more aware of his/her abnormal cognitions and then to compare these with what is happening around them. (Williams, 1984).

Seeing everything in negative terms sets up a vicious circle. Not only do negative cognitions maintain depression, but depressed mood also increases negative cognitions. When a person is depressed, they tend to remember negative or unhappy memories more easily than others, an hypothesis which has been confirmed by research. A larger percentage of experiences recalled by depressed people were unhappy or unpleasant compared with those recalled by non-depressed subjects (Sowa and Lustman, 1984; Teasdale, 1983). The evidence from such studies also indicates that the more severely depressed the person becomes, the greater the proportion of memories they recall that are sad.

Such findings suggest how depression may be maintained by cognitions and forms the rationale for cognitive therapy in depression. However, Beck's theory goes further than this and asserts that 'abnormal cognitions' not only maintain depression, but they may also be its actual cause. This idea is difficult to test. Whether depressed mood gives rise to depressive cognitions or vice versa is relevant to an understanding of depression and its treatment.

Beck suggests that unhappy or distressing experiences in childhood can give rise to packages of depressive cognitions which may re-emerge in adult life at times of stress. It is not difficult to recognise the similarities between aspects of this model and the observations of Brown and Harris (1978). (Fuller attention will be paid to the work of Brown and Harris in the next section).

In keeping with Brown and Harris' findings, cognitive theory predicts that the way a person construes a life event is more important, in the aetiology of depression, than the nature of the event itself. At least some of the vulnerability factors described by Brown and Harris may relate to the development of negative packages of cognitions. For example, the loss of a parent (one of Brown and Harris' vulnerability factors) may generate negative cognitions which can become active again in adulthood when the individual is threatened with another significant loss.

Behaviour therapy and cognitive therapy are not concerned with political or social understanding of an individual's condition. Both are based on learning theory with its emphasis on the depressed person assuming personal responsibility and the expert directing the steps to effect change. Behaviourists see depression as a learned response to either environmental events or thought processes, hence their assumptions that people can learn new ways to behave, without much reference to the interdependence between social context and behaviour.

Sociological claims

Researchers who have adopted a sociological perspective in exploring the experience of depression have shown an interest in the impact of environmental and social factors. These researchers have attempted to place the depressed person in their wider social context. While the psychiatric and psychological perspectives focus on an individual's chemical and psychological states, the sociological perspective highlights the importance of factors such as social and economic circumstances. The importance of gender differences, social networks, social support, life events and difficulties including unemployment have also been identified by those sociological researchers who have enquired into the nature of depression.

Although much of the research and many of he findings are interrelated (for instance, the meaning of social support and an individual's vulnerability), I shall deal with various aspects of the sociological perspective as if they are discrete.

(a) **Gender differences in depression**

Numerous explanations have been offered for the gender differences in depression (Weissman and Klerman, 1977). For example, it has been suggested that women tend to visit their doctors more frequently than men; they discuss distress and other 'psychological' symptoms more openly (than men) with doctors and other professions, as well as with friends (Hinkle et al, 1960; Mazer, 1974; Parry et al, 1973). Another explanation is that under circumstances in which women become depressed, their male relatives might turn to alcohol. However, as

with all research in this field, it has proved very difficult to distinguish effects from causes.

Explanations of gender differences in the occurrence of depression must also account for the observations that, for women, marriage tends to increase their chances of developing depression, while the opposite happens for men (Gove, 1972; Rosenfield, 1980; Fox, 1980; Tennant, Bebbington and Hurry, 1982). That is, married men suffer depression less frequently than those who are single or separated. This has given rise to considerable speculation much of which focuses on the demeaning influence of being a 'housewife' on a women's social status (Oakley, 1982; Gove, 1984). Stereotypes of femininity related to passivity and nurturant roles have also been suggested as contributing to the greater frequency of depression experienced by women. (Oakley, 1982; Brownmiller, 1984).

Feminists argue that women have difficulty freeing themselves from such stereotypes because these tend to be publicly reinforced by doctors and a wider public. In these circumstances, women are much more likely than men to be diagnosed and treated for depression.

(b) **Social networks and social support**

In recent years, the effect of social networks and social support on physical and mental health has been studied extensively. Studies suggest that social network support enhances immunity to illness and maximises adaptation and recovery from illness (Hyman, 1972; Cobb, 1976; Bloom, 1982). Lack of social ties with others has been shown to be an important risk factor which affects psychological well-being, illness and even death (McC. Miller, Ingham and Davidson, 1976; Pilisuck and Froland, 1978; Berkman and Syme, 1979; Mueller, 1980; Turner, 1981; Williams, Ware and Donald, 1981).

Some researchers have challenged the strength of the social support hypothesis. Henderson (1980, 1982), in particular, has questioned the relationship between social support and its alleged positive effects on emotional well-being.

In sociological studies, a major problem facing the researchers has concerned the design of their enquiries. Researchers often seem to be measuring different sorts of 'social support' and 'social network'. The literature is replete with references to methodology which attempts to measure the proximity, frequency of interaction trust and reciprocity involved in social support. These measures, however, tell us little about the meaning of social support for the depressed people, hence my focus, in Chapter 12 on respondents' perception of what counted as social support.

(c) Life events, vulnerability and depression

A common research tool employed by sociological researchers in the area of depression is some form of the life-event schedule. Although methodological issues continue to cloud the role of life changes and crises in bringing about conditions such as depression, many studies have concluded that there is a definite relationship between life events and conditions such as depression (Morrison, 1968; Paykel, 1969; Birley and Brown, 1970; Rahe, 1972; Jacobs, Prusoff and Paykel, 1974; Brown and Harris, 1978; Kobasa, 1979; Benjaminsen, 1981; Pearlin, Lieberman, Menaghan and Mullan, 1981; Brown, Bifulco, Harris and Bridge, 1986;).

Several researchers (Brown and Harris, 1978; Paykel, 1978) have found that individuals who become depressed are more likely than others to have recently suffered a highly stressful and threatening event in their lives. But most of this research has concentrated on depression in women. Less is understood of the social components of depression experienced by men.

Such threatening life events are difficult to investigate and controversy still surrounds their precise definition and meaning (Hudgens, Robins and Delong, 1970; Tennant, Bebbington and Hurry, 1981). Not all life events, even when they are considered severe, have the effect of making the individuals involved in them more vulnerable to depression.

Even when life events have been defined precisely, the link between these and depression is complex. For example, working-class women tend to experience more frequent and severe life events than their middle-class counterparts. Superficially, this might be thought to account for the increased occurrence of depression in working-class women relative to middle class women. However, there is an additional factor. Even when faced with common life events, middle-class women are less likely than working-class women to develop depression. To account for such trends, Brown and his colleagues suggested that the effects of life events on depression are mediated by what they called 'vulnerability factors'.

Certain life events predispose to depression only in the presence of vulnerability factors, which occur more frequently among working-class women than among others. Based on their work in London, Brown and Harris identified four such vulnerability factors applying to women: the lack of a confiding relationship with a spouse or similar partner; the presence at home of three or more children under the age of 14 years; the lack of employment outside the home; separation from one's mother before the age of 11 years (Brown and Harris, 1978).

The last of these vulnerability factors is different from the others. It relates not to the present but to the past. Separation from the mother also proved interesting for another reason. These researchers noted that the depressed women whose mothers had died, tended to show features of depression which were different from those of women who had been separated from their mothers for other reasons, for example, through divorce.

All other things being equal, a woman whose mother died when she was very young was no more likely to become depressed following such a 'life event' than another woman whose separation from her mother had a different cause. Any form of separation from mother at an early age increased the chances of a woman becoming depressed after a significant life event, but the nature of that separation influenced the onset and nature of depression.

Brown et al applied this explanation of vulnerability to depression to other communities, notably in the rural setting of the Hebrides in Scotland. There,

threatening life events were less frequent than in London and depression also occurred less frequently. Not surprisingly, the vulnerability factors found among London women were not so prominent in the Hebrides. In the Hebrides, not going to church regularly emerged as a vulnerability factor, as did departure from the traditional life-style of crofting and fishing (Brown et al, 1979).

Hebridean women who lived in council houses were more likely to develop depression than those who retained the traditional way of life. As in the London study, factors were found that did not increase the risk of depression but influenced its nature. For instance, of the women who became depressed following the death of a close relative, those who were not married took longer to recover than the married women. Among this group of unmarried women, those who were widowed or divorced tended to suffer symptoms which were different from those of the women who had never married.

This model, linking life events (or 'provoking factors') with depression via vulnerability factors, is widely quoted and has had considerable influence on current thinking about the social origins of depression. The work of Brown and his colleagues has been repeated by other researchers in different parts of Britain and elsewhere (Costello, 1982). The basic assumptions about the importance of vulnerability factors have a wide application, although the details vary depending on the setting. For example, the vulnerability factors described above were different in London and in the Hebrides. Another study, from Calgary in Canada (Costello, 1982) has suggested that the vulnerability factors there may be different from those found in London. In a sense, this is hardly surprising. Vulnerability factors may be seen as measures of social support (or lack of it), and the support available is likely to vary from one community to another, and from one context to another. The notion of 'context' has cultural connotations, another topic which I wished to be sensitive to in my own investigations.

A relationship between difficult life events, and biochemical and hormonal changes in depression may seem unlikely, but researchers have begun to discover some links. A recent study (Kraemer, 1985), compared what happened to cortisol levels in two groups of depressed people, those who had suffered a recent severe life event before the start of their depression and those whose depression was not

preceded by such an event. The results suggested that abnormally high cortisol levels were more likely in the group whose depression followed a severe life event.

However unlikely, such links between two very different models of explanation or perspectives appear to exist. An even stronger link exists within sociological perspectives, namely between vulnerability to depression and one's expected social role.

Recent research has suggested that vulnerability is related to the different social roles occupied by men and women (Kessler and McLeod, 1984). These researchers concluded that greater vulnerability of women is explained by the greater emotional involvement of women in the lives of those around them. This emotional cost of caring is responsible for a substantial part of the overall relationship between gender and vulnerability (Kessler and McLeod, 1984).

Another recent study, using a national (American) sample of married couples, showed that economic hardship was increased by low income, low education, being young and having young children (Ross and Huber, 1985). They found that economic hardship, in turn, increased both spouse's depression levels. Other factors appeared to affect the men and women differently. A husband's personal earnings directly decreased his depression, because, the researchers argued, his earning indicated successful fulfilment of his provider obligations. They accepted that the wife's major role obligation is not provider, but homemaker: her personal earnings did not affect her depression, whereas her level of education and the number of children for whom she was responsible, did.

(d) **The effects of unemployment**

Another area of research into what are sometimes called the 'social factors' relates to the potential effects of unemployment on mental health. The suicide rate is higher among the unemployed than among those in paid employment. The unemployed are also over-represented among admissions to hospital following deliberate overdoses of drugs and other forms of deliberate self-harm. A study from Edinburgh (Ullah, Banks and Warr, 1985) showed that deliberate self-harm was at least ten times more frequent among unemployed men than among their

employed counterparts. The rise in the frequency of deliberate self-harm coincided with the rise in the number of men out of work. Although there is only a weak relationship between deliberate self-harm and depression, such data emphasises the considerable impact of unemployment on mental health in general. The values associated with being at work and the meaning of employment and unemployment is part of the context of people's lives, an issue which I proposed to address in my interviews with a sample of respondents in inner Western Sydney.

Among school leavers, those who fail to find employment suffer more symptoms like sleep disturbance, anxiety and feelings of depression than those who manage to find work. However, this result could mean either that those out of work become unwell, or that those who start off unwell are less successful at finding work. Researchers in a British study (Banks & Warr, 1982), screened more than 1,000 16 year-olds before they left school and no differences were found in mental health between those who subsequently became unemployed after leaving school and those who succeeded in finding a job. It appears that the failure to find work leads to a deterioration in mental health, as manifest in symptoms of depression. Such symptoms of mental distress fell sharply when those who had been unemployed managed to find a job. Another study involved a group of men who faced unemployment because of involuntary redundancy (Melville, Hope, Bennison and Baraclough, 1985). When faced with redundancy, more than one-third of the men had symptoms like poor sleep, fatigue and feelings of depression. That unemployment produces adverse psychological symptoms and that utilisation of health services increased substantially was shown in a 1985 study (Linn, Sandifer and Stein, 1985). These researchers found that social support is a potential mediator of stress. In other words, in that study, unemployment stress for the respondents was exacerbated by a poor sense of social support.

The effects of unemployment on mental health in general and on depression in particular are mediated by a number of other factors. For example, in terms of its effects on mental health, unemployment, may appear, at first sight, to have a greater impact on the middle-aged compared with younger or older people. It has also been suggested that financial assistance and practical help tends to protect the individual against the harmful effects of being without work. A recent

American study looked at black women who viewed themselves as unemployed and those who viewed themselves as homemakers. The researchers found that employed black women and homemakers did not differ significantly in the level of depressive symptoms. On the other hand, unemployed women were significantly more depressed than employed women, irrespective of age, household income, level of education, marital status and the presence of children in the household. Although poor physical health was related to high levels of depressive symptoms for unemployed and employed black women, what was called 'high religiosity' and satisfactory perceptions of social support from family members and friends were considerably more important in reducing depression among unemployed women in contrast to employed women (Brown and Gray, 1988). Such findings are linked to the previously discussed claim about vulnerability and expectations about social role. This point about role performance, is another topic which has influenced my own consideration of the social context of depression.

Sociology: what about treatment?

While sociological perspectives strive to understand the depressed person in their social context, they are silent on the form that intervention or treatment should take. Unlike the psychiatric and psychological perspectives which have developed theories of therapy or treatment, the sociological perspective offers only accounts of the associations of depression. This shortcoming in sociological perspectives seems inherent in the nature of the discipline: concerned with description and explanation but having little responsibility for responding even to their own findings. Psychiatry and psychology incorporate a strong 'clinical' or treatment-oriented approach. Sociologists have shown little interest in treatment.

The closest translation of sociological findings to a treatment modality can be found in social work. The intervention offered and the effectiveness of social workers in the management of depressed female patients in general practice has been studied (Corney and Clare, 1983; Corney, 1984). Their findings concluded that women with 'acute or chronic' depression benefited from social workers' intervention. These women were assessed initially as having major marital or boyfriend problems. Four aspects of social work intervention proved to be beneficial.

First, the activity of sustaining and exploring was important. This enabled the client to develop awareness and understanding of the dynamics of their personal situation, behaviour and attitudes. Secondly, the use of certain 'behavioural techniques' such as devising contracts and setting tasks was helpful. Thirdly, the provision of information and advocacy by the social worker were rated by the depressed respondents as important activities. These respondents also found the direct provision of material aid and specific services of great benefit.

Corney and Clare's finding that the majority of patients found the social worker supportive and they appreciated having someone 'independent' to talk to and confide in matched with Rees and Wallace (1982) conclusions about the forms of social work intervention which are highly valued by clients in general. That is to say, this group of depressed women, much like the clients in that 1982 survey, found the emotional support and practical advice given by the social worker of more importance than the social worker's technical skills and activities in counselling alone.

Different types of depression or just different explanations?

There are numerous different theoretical perspectives to explain the causes of depression and the justification for the treatment of such a condition. One might be excused for thinking that perhaps there are different types of depression which different models of explanation have claimed as their own. Many, especially within the psychiatric school, would argue this. Others have their reservations, yet are equally single-minded in advancing their explanation or model as the valid one when explaining the phenomenon of depression and its treatment.

There are controversies, convergences and some surprising links between models of explanation which have no common starting point. However, several questions have been given little attention. Under what social and economic conditions do people experience depression? How do they describe such an experience? How does the social impact of their lives affect any considerations of treatment? Answers to these and related questions were investigated in my interviews with 80 respondents who lived in inner city Sydney during the late

1980's. How these respondents were chosen, in what ways their depression was assessed and how they accounted for the meaning of their condition in relation to the social context of their lives, is addressed in the following chapters.

CHAPTER 2

ACCESS TO LIVES AND LIFESTYLES

Introduction

In an attempt to avoid presenting an account of research methods as an unappetising ingredient by comparison with the rest of this study, I will explain my research in the form of a story. The first part concerns the birth of a research idea. This idea grew into a project which included various mechanics of co-operation with colleagues and respondents. Thirdly, I will make a brief reference to a profile of the sample. Fourthly, I will acknowledge what the pilot study taught me about interviewing and about adapting research instruments to my purposes.

Genesis of an idea

In this story, I feel obliged to admit to a sense of constant doubt about research design, the frustration of 'doing research' and to a feeling of pleasure at unexpected discoveries. My commitment to examine the social contexts and treatment of depression punctuated a process in which I have been involved for about a decade. It was a process of exploration, reflection and intervention with experiences labelled 'depression'.

As a social work practitioner in very different settings, I became aware of the ubiquity of depression. In a psychiatric hospital, depression was no stranger. In another agency, in which I worked as a member of a rehabilitation team, it was also evident among the injured workers and bereaved wives. Later, in my practice as a social worker in a childrens' hopsital, depression was a common problem for families of very sick children. Subsequently, I also encountered first hand accounts of depression from men and women who had been referred to a community health centre by local doctors and other helping professionals.

The client's depressive episode was not always bluntly stated. People rarely talked openly about 'depression'. In my experience, they were more likely to use euphemisms such as 'feeling low', 'being down', 'having nerves', 'feeling out of sorts', 'being blue' and the like. Commonly, people would try to 'figure out' the cause of their depression. Although some people would appear almost totally self-blaming, others sought explanations which combined personal and social considerations. For instance, in the psychiatric setting, the patients with the 'mental health problem' might well complain that they would be 'better off' if others, like employers gave them a 'fair go'.

Stereotyped attitudes to such patients on their discharge from hospital sketched them 'fighting the system' and often becoming depressed in the process. In a very different context, the injured workers in the rehabilitation setting saw their depression as being caused partly by their 'negative attitude' to job loss as well as by a harsh system in which dismissal of an injured worker was a common practice. In another setting, the young mother of three toddlers under five who found herself unable to cope thought she was inadequate, yet also saw that if child care had been more readily available, she might have felt less 'low' and would have coped more easily. Such cases were not uncommon in my caseload.

Although presentations of depression have pervaded every work setting in which I have been involved, the present study arose from what I perceived to be a gap in knowledge. Literature abounds concerning the alleged association between life events and difficulties, social supports and social bonds and the experience of depression (Brown and Harris, 1978; Henderson, 1983; Tennant and Bebbington, 1978; Surtees, 1980; Costello, 1982; Ell, 1984; Ryan, 1986). There is also some evidence regarding the effectiveness of certain types of treatment, for example, pharmacological (Hollister, 1978; Klerman et al 1974), psychotherapy (Weissman, 1979) and social work intervention (Corney, 1983). However, there has been little attention paid to the social contexts of individuals' depression and the non-medical treatment alternatives available to them.

The gap in knowledge, or rather, in assumptions about the nature of depression and its treatment became apparent to me when I was attached as a social work consultant and practitioner to the Sydney University Community

Medicine's General Practice Unit. A majority of patients referred to me by my general practitioner colleagues were said to be suffering 'neurotic depression' or 'anxiety and depression'. Another striking feature of my caseload in that unit was the large number of women referred.

Discussion with general practitioners and social work colleagues about the most appropriate sample from which I might discover significant features of the social context of depression, included the controversy as to whether to interview only female respondents. Those who urged me to do a 'feminist analysis' and restrict my sample to women only contended that I would be able to isolate specific factors by concentrating on depression as experienced by women.

Tempting though it was to confine myself to women's experiences only, I decided to include both men and women in my research. I made this decision for the following reasons. First, evidence about women's vulnerability and explanations of the preponderance of women suffering from depression have been documented (Seligman, 1974, Clancy and Gove, 1974; Weissman and Klerman, 1977; Radloff, 1975). Secondly, an interesting feature of the referral pattern from general practitioners to me as a social work practitioner, was that with reference to the men who were referred, my doctor colleagues often hinted at 'depression' even though these male patients were said to have alcohol problems, sexual difficulties, or, more particularly, 'psychosomatic problems'. Although different terminology was used by the general practitioners, and by the patients themselves, both men and women experienced depression, and I suspected that common social conditions had similar effects on them.

However, it is important to acknowledge that my interest in examining depression and its treatment began with a more narrowly defined research idea. I originally wanted to examine the constraints affecting doctors' treatment of patients in that one general practice. Although such a project might have explored the experience and treatment of depression, I decided to widen the scope of my enquiry to include many more respondents drawn from three local government areas and doctors in 20 general practices. The rejection of one project led to the birth of another. This false start was crucial in the effort to specify a researchable question and improve the design of a project.

There were a number of difficulties with confining the research to one general practice. First, the University's General Practice Unit might be considered to be unique and in consequence to service a particular sort of clientele. Several colleagues pointed out that the University's general practice was run by one full-time general practitioner and three sessional medical academics from the Department of Community Medicine. This gave the practice a different status to other urban general practices. As a result of this peculiar status, it seemed that there would be bias in terms of patient population: many local people would be attracted to such a practice and attach some privilege to attending while others, for similar reasons, would shy away from 'the University's' practice. Consequently, the sample would not be 'representative' of the depressed people and patients in that area. Further, in terms of doctor style, some colleagues cautioned against assuming that the academic general practitioners were 'representative' of general practitioners. In this respect, further bias would be introduced into the research if the project was confined to that one practice.

Secondly, as a practitioner-researcher in an action-research project, it would be difficult to evaluate my own intervention. That intervention would have to be evaluated by a third party and this would introduce another and an unnecessary dimension into the research.

Thirdly, by confining the research to one general practice, the sample would be smaller and the time needed to gain a reasonably workable sample would be unrealistically long. My aim to interview at least 50 respondents would take far longer to achieve by referrals from doctors in one general practice, than by other means, such as survey sampling or referrals from several general practices.

In terms of the sample of general practitioners and their perception and treatment of depression, it also made sense to gather as many responses as possible. By confining my research to one general practice, I would only have four doctor respondents. By widening the study I could document the views of many more general practitioners. In doing so, I would be addressing my critics' claims about the shortcoming of taking a sample from mostly 'academic' doctors, and would be likely to interview other practitioners of different backgrounds serving a population of considerable diversity in terms of ethnicity, social class and age.

The Mechanics of Co-operation

In my 18 months' attachment to the General Practice Unit, a degree of trust was built up in my relationships with my medical colleagues. This 'trust' was very important in such an inter-occupational partnership. I was fortunate to have colleagues who were enthusiastic about my presence in the practice and committed to developing a service that defined health as being far more than the successful treatment of an illness. Research was valued in this Unit and several of the doctors had developed models of health which had a psychosocial focus. Nevertheless, even with the benefit of similar ideologies and a strong commitment to inter-occupational co-operation, trust and credibility had to be earned and maintained.

My credibility was established in a process of partnership and perhaps by the outcomes in a number of cases which were referred to me. Given the difficulties which doctors have been described as experiencing in referring outside medical networks (Huntington, 1983; Mullaly, 1988), three particular experiences were important in their influence in the research.

(i) developing a sense of shared interest in research

(ii) identifying how a heterogeneous sample of patients and practitioners might be drawn

(iii) obtaining insights into doctors' assumptions about (a) the prevalence of depression (b) the symptoms by which such a condition is recognised and (c) the appropriate forms of treatment.

Collaboration with the Department of Community Medicine allowed me to gain access to a wider population of respondents and general practitioners. This opportunity presented itself when the Department decided to conduct research into the extent of community morbidity and use of health services. The medical researchers in that Department hypothesised that reliable information about general morbidity could be obtained just as easily, and at far less expense, from a survey of general practitioners' patients rather than from random surveys of the general population.

These medical researchers intended to use the following method. Randomly selected general practices would record morbidity in their practices. A sample of their patients would be interviewed within two weeks to obtain self-reported morbidity information. The same information would be obtained from another sample, a household survey of patients who had attended a general practitioner within the past two weeks. This survey, with its two sample groups would take place in three local government areas in inner Western Sydney (with a total population of 151,000, served by 170 general practitioners) of Ashfield, Burwood and Strathfield. These areas were chosen because the population was accessible to the researchers, was considered to be relatively 'stable' and included a 'range' of socio-economic and ethnic groups. These assumptions were made on the basis of familiarity with the 1981 Census data, which was then the latest available. (A profile of this population as at 1981 figures is given in Appendix 1).

The morbidity study was to include two surveys using one questionnaire but different samples. One sample would comprise 500 general practice patients, identified by addresses and phone numbers. The other sample of 500 would be selected on an area probability basis from the areas mentioned. The project began with pilot testing on a sample of 50, half of whom were general practice patients and half randomly selected households.

By using this same sample of people to draw from, I could widen my research project to include many more depressed people and general practitioner respondents. Initial agreement to allow me some 'space' on the questionnaire to include a few screening questions on depression was gained from the Head of the Department of Community Medicine and the principal researcher.

Now begins the story of the real test of co-operation, tensions, negotiation and finally, agreement on my research methodology. Over a period of six months during fortnightly meetings, a workable arrangement in terms of co-operation and trust was effected with my medical colleagues and the private research firm which was brought in to conduct the fieldwork regarding the extent of community mobidity. Lest this process sound too simple and idyllic, let me elaborate.

In regular meetings over a period of six months, a workable arrangement in terms of co-operation and trust was effected. There were battles along the way which concerned the number of questions I could have on the questionnaire, their wording, position and 'status'. A major bone of contention concerned the issue: would the survey research team include my questions in the 'short interviews' done at the door with those respondents who would not form part of their sample. Some of the survey team thought it would be 'inappropriate' to ask 'personal questions' about depression of those respondents who would not be interviewed and who only could give minimal demographic details to the interviewer at the door. Ultimately, my screening question was included in these short interviews with a lead-in statement which said 'A researcher at Sydney University etc..' (see Appendix 2.)

There were differences of opinion between my medical colleagues and between them and the representatives of the private research firm who were contracted to conduct the fieldwork. An attempt was made by the private research firm consultant to exclude my questions from the questionnaire. These controversies were contested not only by me, but also by others who saw merit in examining the experience and treatment of depression. My medical researcher colleagues, their research assistants as well as my supervisor saw fit to support my contentions and did their best to persuade those doubters of the 'reliability' and 'validity' of my research question. That hoary old chestnut about the value of 'quantitative' versus 'qualitative' research was raised repeatedly. On one occasion we seemed to agree to differ. I emphasised the qualitative dimension of research and my medical colleagues referred to the importance of the size of a sample and paid due respect to quantity. My research was not to be a laboratory experiment in which control and experimental groups could be isolated and studied. Nor was I going to test an hypothesis. My objective was to produce a life-like picture of the social contexts associated with depression and the interface between individual's experiences of depression and the varying professional and lay responses to these people and their condition.

Originally, the Community Medicine researchers agreed to include three screening questions about depression on the questionnaire to be administered to their sample. Although my research question had little in common with those

which were being addressed by that other Department, it was both appropriate (that is, my questions were in keeping with the general tenor of their questionnaire) and indispensable to incorporate the screening questions on depression. By doing so, I was increasing the possibility of gaining a heterogeneous sample in a demographically interesting area of inner city Sydney.

After a number of discussions about the ethics of proxy responses, it was decided to ask one specific question about depression only of one respondent. The person who answered the door in the household survey became the respondent who was asked about his or her experience. That person who answered the door was not asked to speak for any other member of the household. Although, initially, I disagreed with the view taken by my medical colleagues on this issue, I became convinced of the wisdom of their argument that it would be unethical and probably unreliable to have people giving accounts of other people's depression.

Following a number of consultations with psychiatrists who were acknowledged epidemiologists and researchers in the field of depression, it was agreed that there should be one screening question included. There were several reasons for this. First, my aim was not to assess the frequency of depression in the population. Secondly, I wanted a definite 'yes' to my question, answered by the respondent first interviewed. Thirdly, the merit of asking people to make a commitment to being interviewed then and there, as it were, was questionable: it could be interpreted as a form of pressure. Instead, I decided to leave a letter with those people who answered 'yes' to the 'depression' question. This letter informed them of my interest in interviewing them and asked that they contact me by phone or return a detachable lower portion of the letter with basic details of name, their interest in being interviewed, their phone number and preference of time for contact. The original letter, and the follow-up letter are shown in Appendix 3.

As a result of all the consultations and discussions, it became clear that I needed a sample of people who had experienced a depression. This sample could be gained by asking one screening question in the household survey. This question was :

> 'In the past year, has there been a period of 2 weeks or more in which you felt sad and down and when you lost interest and pleasure in things that you usually care about and enjoy?'

The various psychiatrists and researchers whom I consulted advised that I jog the respondent's memory only with regard to the past 12 months. It was claimed that beyond that point, people's memories become hazy and unreliable. Within a shorter time frame, it was assumed that respondents' recall would be more accurate. People's accounts of depression, their feelings about their condition and the means of treatment would still be relatively fresh in their minds within a twelve month period.

The criteria of 'two weeks or more' to determine the 'legitimacy' of the depressive experience has been used and found to be reliable by other researchers whom I consulted. There is a strong body of opinion that any shorter period of time cannot be regarded as a depressive episode. This temporal element is important. It distinguishes depression from everyday unhappiness. The literature is replete with this distinction and it is a valid one. Unhappiness is sometimes thought to be identical to depression, yet the former affects feelings and mood for only a short time, perhaps a few days to a week, hence the importance of the definition of being very low as a criterion to determine the existence of depression.

However, the time factor, the duration of feeling low, is not enough for the diagnosis of depression, nor is the state of mind, that is, 'sad' or 'down'. In addition, a depressed person is expected to show a cluster of associated symptoms which occur over a period of time and are associated with mood. Such symptoms include poor appetite or weight loss, or increased appetite and weight gain, trouble in sleeping, tiredness or agitation, a loss of interest in usual activities, a decrease in sexual drive, feeling of self-condemnation, difficulty in thinking or concentrating and thoughts of death or suicide. Of course, not all of these symptoms will be present in each person. The researchers whom I consulted were of the opinion that the single symptom which 'speaks loudest' is that of losing interest or pleasure in activities that are usually enjoyed. Therefore, if a firm indicator of depression symptomatology was to be derived from one screening question, then the 'loss of interest' symptom had to be raised.

When the pilot study went ahead, one screening question on depression was included. My objective was to identify those people who had experienced a depressive episode as identified by them, and to conduct more intensive interviews with those who were willing to be interviewed. This screening question was as follows:

> 'A researcher at Sydney University is also doing a survey on a common problem in the community. Could you tell me if in the past year, there has been a period of two weeks or more in which you felt sad and down, or when you lost all interest and pleasure in things that you usually care about and enjoy?'

If the answer was 'yes', the interviewer would say:

> 'I'll leave this letter with you. It tells you a little about the researcher, and how you might contact her'.

What follows is an account of the course of events and the research instruments used following this screening process.

The Research Instruments Used

For both the pilot and the main study, three instruments were used: (i) an interview schedule based on Brown and Harris' (1978) Interview Schedule for Events and Difficulties; (ii) the Zung Self-rating Depression Inventory (1965) and (iii) a self-report Social Problem Questionnaire developed by Corney and Clare (1985) (see Appendix 4).

Although I expected to refine some aspects of these instruments, they were used for the following reasons. Since I was investigating the social contexts of people's depression, I needed an instrument which provided insight into those areas. The Brown and Harris Events and Difficulties schedule seemed an appropriate instrument for my purposes. This interview schedule is comprehensive and includes questions about the social context of people's lives. It is divided into discrete areas covering health, past health, role changes, leisure and interaction, employment, housing, money, crises, forecasts, marital relationships, interaction with parents, resources and a general section. Each

area contains questions not only about the respondent's experiences in the past 12 months, but also about other topics which affect the quality of people's lives over a longer period of time (see Appendix 4). As I had confined my screening question on depression to events in the previous 12 months, it made sense to use an interview schedule which also concentrated its questions on experiences over that period.

For data collection purposes, the Brown and Harris interview schedule seemed tailor-made, but how I used it needs some elaboration. The interview schedule is standardised, but I developed it for my own purposes. Individuals have unique ways of defining their world and I wanted to document it from each subject's perspective. I wanted informality and open-ended discussion. Ann Oakley had impressed me with her observation that if she had used the 'sanitised' interview demanded by textbook writers, she would have ruined her relationship with her respondents. (Oakley, 1979, 1980).

I followed the maxim of the interview as a 'conversation with a purpose'. I used themes and topics to form questions in the course of conversation. An early user of this technique of allowing the respondents an opportunity to develop answers outside a controlled and structured format was Mayhew who said:

> 'It surely may be considered curious as being the first attempt to publish the history of a people from the lips of the people themselves - giving a literal description of their labour, their earnings, their trials, and their sufferings, in their own 'unvarnished' language; and to portray the condition of their homes and their families by personal observation of the places, and direct communication with the individuals ...' (1851, p.iii)

From my practice not only as a social worker, but also as a fledgling researcher, I believed that establishing a relationship with the interviewee or respondent would be indispensable in helping the respondents to feel comfortable. The surroundings and the atmosphere of the interview should be non-threatening. The most conducive place to interview people was and is in their own homes. Interviewing people in their own homes, in a much more 'natural' setting than in an office, also has another research benefit. It allows the researcher to observe some aspects of the way in which people live. Taking in the decor, the colour

scheme, the ornaments and icons people use to decorate their surroundings is part and parcel of their social context. I also assumed that such an environment would say something about the meaning of depression.

I found that when interviewing people about sensitive or personal areas such as their experience of depression, it was important to remember to explain to them why I wanted to conduct the interviews and what would happen to the interview material.

Before each interview began I explained that I had an agenda of topics that I wanted to cover. I explained something of the aims of my interview and the manner in which I would record what they said. I proposed to write things down while they talked. I also indicated that they were free to seek clarification of any points or to disclose their discomfort with any questions. Finally, I asked each respondent to tell me anything they felt I had omitted, any issue which they thought ought to be included to explain their situation, or would be helpful to me in meetings with other interviewees.

The interview procedure having been clarified, the interviews began and on average, lasted two hours. One other procedure which I followed before each interview was to request that each respondent answer two short questionnaires, at some point. I usually completed this formal part of the interview after two or three hours of open-ended interviewing.

The first of these questionnaires was the Zung self-rating depression scale. This instrument was used to discover how many of the respondents currently were experiencing a depression and of what severity. This instrument is considered by some to be the 'soundest psychometrically'.

Respondents were also asked to complete the Corney and Clare Social Problem Questionnaire (SPQ). This self-report schedule had been developed from an original, longer standardised Social Maladjustment Questionnaire. Corney and Clare had wanted to develop a short, reliable self-report social questionnaire to measure the nature and extent of social adjustment and functioning. They tested the SPQ against the Social Maladjustment Schedule and found the former to be

readily acceptable by respondents and useful in its measure of the presence or absence of social problems. As an adjunct to my non-standardised interview and as a shorthand way of recording and analysing the incidence of social problems, this seemed to be a promising instrument. It proved valuable, in particular in providing a means of contrasting the clinical criteria highlighted in the Zung inventory with social issues.

To interview the general practitioners, I devised my own unstructured interview schedule to cover the following areas: nature of practice, area, method of payment, length of time in the practice, doctor's views on the nature of depression, the associations and causes of depression, their views on the medical and non-medical treatment of depression. These specific areas were chosen after consultations with my medical academic colleagues and two practising general practitioners.

The Method: The Pilot Study

i) **The depressed respondents**

The ten respondents in the pilot study were drawn from the two samples of the Community Medicine Household Health Survey, as discussed above. In this pilot exercise, the three research instruments, the interview schedule, Zung depression scale and the SPQ were used.

The pilot study revealed the necessity to amend some questions, omit others and add some which addressed the constraints of living in urban Australia in the 1980's. The areas where questions needed changing were in the 'social support', 'relationships' and 'forecasts' sections. The pilot study also highlighted the need to add questions about the respondents' first experience of depression, any subsequent depression and their views on the benefits of medical and non-medical treatment.

With regard to the two self-report instruments, the respondents in the pilot had neither hesitation nor difficulty in completing them, although three people preferred to respond to the questions by having the researcher write down their answers. It was apparent that the respondents not only had little difficulty in

completing these questionnaires, they also enjoyed the chance to focus their attention on assessing themselves and their circumstances.

(ii) **The general practitioner sample**

For the pilot study, I interviewed two general practitioners about their views on depression and its medical and non-medical treatment. Both these doctors were more than amenable to being interviewed so I was lulled into a false sense of security about the accessibility and agreeableness of all other general practitioners. Later, I was to receive a rude shock.

The pilot study revealed a number of deficiencies in my interview schedule for the doctors. In particular, there was need to be clear about depression and whom it affects. In this way, I could refer to my own interpretation of depression and so, if they asked, provide them with a definition to which they could respond. A more specific explanation of the meaning of medical treatment and the doctor's views about non-medical treatment was needed. The notion of 'treatment' could not be taken for granted. The idea of non-medical treatment had to be explored. These extra topic areas were included in the final version of the interview schedule.

Finalising the research instruments

As a result of the pilot interviews with depressed respondents and general practitioners, a number of amendments were made to my research instruments.

In the pilot study, the word 'depressed' was used after 'sad' and 'down'. The survey interviewers reported that the word 'depressed' was too 'strong' and 'clinical'. A large number of these interviewers believed that some respondents were 'frightened' by the word and reluctant to admit to the experience. Their feedback was welcomed and after vigorous argument for and against the word's inclusion, I decided to delete it, a decision which had been foreshadowed by one of the epidemiologists whom I had consulted. He had said that although there was merit in being 'proper and correct' and using the word 'depressed', he saw some obstacles. In his view, the alternative words, 'sad' and 'down' were best presented

alone, as many people would not describe themselves as depressed even if they were. He contended that the word was probably not widely used by the general population. On the other hand, words such as 'sad' and 'down' were commonly used by people when describing depression.

Ultimately, there was general agreement that the words 'sad' and 'down' and the remaining reference to 'of loss of interest and pleasure' would capture the purpose behind the question. The final version of the question which went to the 1,000 households did not include the word 'depressed'.

Although the two self-report measures, that is Zung and the Corney and Clare SPQ were retained unamended, both the interview schedules for respondents and doctors were changed in accordance with my experiences in conducting the pilot studies. These experiences included direct comments from respondents and my realisation that some words were clumsy, some questions ambiguous and others loaded. On some issues the line of questioning was too sparse. For example, with regard to my appraisal of each individual's experience of social support, more needed to be asked. On the other hand, there was too much questioning in another area, that of health problems over a life-time, and I therefore pruned the number of questions on this topic.

The final version of the interview schedules appear in Appendix 4.

The Method: The Main Study

(i) **The depressed respondents**

For the main study, 80 respondents were drawn from two samples. Three hundred and forty three from the 1,000 people surveyed answered 'yes' to the screening question. Those respondents who answered 'yes' and who contacted me, were offered an interview. Of those 112 who made contact 32 did not reach the interview stage. The final sample of 80 were those who were prepared to be interviewed. People gave several reasons for deciding that they did not wish to be interviewed. For example, some, on learning of the time and commitment required to take part, said they did not wish to do so. Many had thought the

interview would be a brief phone call instead of a detailed face-to-face interview. These decisions were respected.

Although some people baulked at the idea of being interviewed at home, most people welcomed this arrangement. Of all the respondents, only six were adamant that they preferred an office interview. They wanted to be interviewed privately, away from what one woman called 'preying eyes and ears'. In each case, the respondent thought that a home interview would not afford sufficient privacy. In these cases, the interview was conducted in my office.

A striking feature of the interviews was each respondent's willingness to talk, as though they had been waiting for years for the opportunity to unravel something of themselves and their circumstances. In many cases, respondents said they had felt under a tremendous pressure to talk through their depressive experience, while others expressed an absolute desperation to 'tell someone how terrible it really was'. At least four respondents said they hoped this research interview would lead to further contact. They regarded the research interview as therapeutic. They wanted more such interviews. In two cases I felt bound to refer the people to a specialist out-patients clinic. This act of referral, which promised them the possibility of contact with another helping professional was a decision made on ethical grounds, i.e. attention to these individuals' mental health had to take priority over research interviews. But the act of referral elsewhere could be regarded as therapeutic in itself.

After each interview I thanked the respondents for their time and energy and followed this up with a letter of acknowledgment a week later. This piece of courtesy and expression of gratitude resulted, in six cases, in people contacting me again to say not only how pleased they were to be so acknowledged, but also that such acknowledgment was a relatively unique experience in their lives. Such a reaction I regarded as a useful insight into the social context of depression and not merely as a feature of research methods. Even the verbal acknowledgment was important to all the respondents. Several asked that I contact them at the completion of my research to inform them of the results.

(ii) The general practitioner sample

In the main study, 20 general practitioners were interviewed. After the ease I experienced in contacting and interviewing the two doctors in the pilot study, I was to receive a succession of shocks. It was often difficult to reach the doctors. Their secretaries acted as gatekeepers and were sometimes reluctant to put me through to the 'busy doctor'. On most occasions, either the receptionist or the doctor wanted to know my full credentials and reasons for conducting research before any serious consideration was given to my request for an interview. The doctors and the gatekeepers wanted to be assured of my status, a test, apparently, of my professional and moral worthiness. The people suffering depression had not wanted any such test. Although the refusal rate from doctors was small, it was difficult to accept that some of them did not have the time or the inclination to set aside 20-30 minutes to discuss such a common and important complaint as depression.

After the first few telephone calls to enlist the co-operation of the doctors, I discovered a certain pattern. I developed a strategy which worked in almost every case. The pattern to which I refer was some reluctance by the secretary to put me through to the doctor in the first instance. Once through to him or her (usually him), there was invariably a need to 'sell' the interview and its importance.

My strategy was to use certain 'key' words which would lend me credibility. I told them how I came by their names and my collaboration with my Community Medicine colleagues, with whom these doctors had already co-operated. Next, I introduced the idea of the research and in particular, the short interview which would help me to get a 'better understanding of general practitioners' views and treatment of depression'. I was very conscious that the doctors were much more suspicious than the depressed respondents. The doctors did not wish to be even slightly under another's control, in the sense of agreeing to be interviewed by someone whom they did not know. The issue of my not being a 'medical doctor' was raised by some, but was apparently only regarded as a serious shortcoming by one doctor.

My introductory remarks were usually followed by a short discussion on the prevalence of depression. There were two notable cases where this did not occur. In those two cases, the doctors insisted, 'I do not see much depression in my practice', 'you can talk about it but it is not a problem for my patients'. I thought it was important to interview these doctors and I managed to secure an interview with each of them.

Doctors also expressed their concern about making a commitment of time. As a rule, I adjusted my timetable to their schedule, although I was seldom prepared to sit in a waiting room until the doctor had time to see me. One secretary and one doctor (not in the same practice) suggested that this was the only way in which time might be found which did not interfere with the doctor's busy schedule. They apparently did so on the assumption that the doctor's 'time is money'. My view was that my time was also valuable and not only in monetary terms. In accommodating to the doctor's schedule, I found myself in their surgeries at 7.30 in the morning, at lunch time, at 6.30 in the evening and beyond. But without such persistence, the general practitioner sample would have remained elusive. Besides, the task of tracking down the doctors was not just a methodological obstacle. It also provided me with some insight into the vexed question of access, not only from my perspective, but also from potential patients' points of view.

Lessons along the way

I was warned by four researchers before I set off on my research journey that there would be 'difficulties' in enabling respondents to understand what was being asked, that is, in the way that the researcher intended the questions. They complained about 'subjects' generally making the researcher's life 'difficult' by not giving succinct answers, straying off the point and asking questions back. I did not encounter such 'difficulties' except perhaps with a couple of general practitioners.

I was frustrated by some answers, embarrassed at times by the intimacies shared and annoyed by occasional prejudiced and stereotyped remarks. I welcomed such experiences. I learned that although it was tempting to dismiss or

discard information which did not fit the supposedly elegantly constructed glass slipper of research design, such information was data and all the more valuable for being unexpected.

Much of the data which emerged from the interviews was rich and telling. It mattered desperately to the respondents and often pointed me, as the researcher, in a far more interesting direction. My interaction with respondents encouraged me to develop conversations, to listen to respondents' suggestions and in several instances to follow their advice about the best ways to obtain an apt picture of the social context of depression. I thank the respondents for that. For example, one young woman asked me pointedly after the interview why I had not included an explicit question about the use of alcohol. She said that when depressed, alcohol was her 'salvation' and her own form of non-medical treatment. Another respondent said she wanted to be asked about the value of religion in her life. Thereafter, as a matter of routine, I asked about the use of alcohol and the value of religion.

I have pondered on the reasons for others' caution about the 'difficulties' of research. One of the reasons for such difficulties is that the world which interests the researcher is not always the world which interests the person being researched. In my research, this lack of fit did not seem to occur. My social work practice experience and my own introduction to research into health and welfare issues had developed because of my fascination with the question of depression and with people's vulnerability to such an experience in urban Australia. I was interested in depression, not just from an academic point of view, but also from the perspective of each respondent. I was eager to understand and empathise with their experience. For their part, the respondents were self-selected and willing to tell their stories. In these respects, my world as a researcher was very much in keeping with my respondents' worlds as the people being researched. We were both interested in trying to unravel the meaning, the causes and the most appropriate forms of treatment for a common and debilitating condition.

PART II

PARTICIPANTS IN CONTEXT

CHAPTER 3

RESPONDENTS AND GENERAL PRACTITIONERS

This research occurred in the local government areas of Ashfield, Burwood and Strathfield. The total population of the area was 151,000 (as at 1986 ASB). Within these three inner-western areas are discrete suburbs. Ashfield, Summer Hill, Croydon, Croydon Park, Dulwich Hill, Haberfield, Burwood, Enfield, Strathfield, South Strathfield, Strathfield West (sometimes known as Homebush West).

These suburbs, within the geographical boundaries of the three local government areas, have much in common, yet are also very different. They share similar geography in Sydney's inner west, and a range of socio-economic and ethnic groups live there (ABS 1986). There are pockets of wealth and deprivation, often in one suburb. For instance, although Strathfield has always been regarded as a garden suburb, and a fashionable address, the range of accommodation varies considerably, from mansions on the Boulevard (allegedly, the best street in the suburb) to high rise flats next to one of Sydney's busiest railway lines. To real estate agents and locals, the streets running immediately off the Boulevard comprise what is known as the 'Golden Mile'.

Within the suburbs of Croydon, Burwood, Enfield, Homebush, Summer Hill and Ashfield, standards of accommodation vary. There are comfortable bungalows in tree-lined streets as well as small flats and units located either near the busy main roads or the railway line. These areas are older, established suburbs, with residential and industrial pockets clearly in evidence. From a political viewpoint, the suburbs have shown a 'swinging' tendency in the past few Federal and State elections. Once quite affluent, conservative and established parts of the electorate, like the seat of Lowe, have shown that people will vote ' out of character' when conditions change and people feel let down by a party's platform and record.

Although I did not visit any respondents in what could be called 'mansions', there were some whose living conditions were comfortable, if not privileged. Most of these people either owned or were buying their homes. I also visited people in homes they were renting, either privately or from the Housing Commission. These rented homes and flats varied in comforts and standard of maintenance. The cost of the rents appeared to reflect the standard of the accommodation. An exception was a single mother who rented a low cost new Housing Commission house. She had waited five years for this accommodation for herself and her three children.

The working environments of the 20 doctors also varied in comforts and maintenance. There were surgeries which were shopfronts and others which were located in the doctors' homes, part of which had been converted into surgeries. All of the doctors employed receptionists, but six of the 20 only had part-time receptionists. These doctors did their own reception work some of the time, usually when they did not expect to be busy. The principal reason for this was to economise. Several doctors explained that their overheads were high and any cost-cutting measures had to be considered. Cutting a receptionist's hours was a first step in any economy drive. These doctors practised in the same areas where the 80 respondents lived but it is important to recognise that in only a few cases were they the respondents' general practitioners. The doctors were interviewed not only to obtain their views on the nature of depression but also to provide an extra perspective on the social context affecting the lives of the public in general and the 80 respondents in particular.

Respondents' Backgrounds and Resources

The following tables and commentary provide a profile of the 80 respondents. For example, their ages ranged from 17 to 80, the youngest being female and the oldest a male. (Table 3.1).

There were 56 (70%) female respondents and 24 (30%) male respondents. The largest cluster, 26 (33%), were in the 35-44 age group. The largest representation of men was in the 45-54 age bracket. The 15-24 and 75+ age group

were the two least represented categories.

Table 3.1: Respondents' Age and Sex

	15-24	25-34	35-44	45-54	55-64	65-74	74+	Total
Male	0	3	5	8	6	1	1	24
Female	3	11	21	7	10	3	1	56
Total	3	14	26	15	16	4	2	80

Of the 80 respondents, 44 (55%) were married or living in an established de facto relationship (Table 3.2). Eleven of the sample (14%) were divorced or separated. Fourteen respondents (18%) were single although this did not always mean that they lived alone.

Table 3.2: Marital Status of Respondents

Marital Status	Male	Female	Total
Married/De Facto	12	32	44
Separated	2	4	6
Divorced	1	4	5
Widowed	3	8	11
Single	6	8	14
Total	24	56	80

Where people were born

Of the people counted in the 1986 Census (Australia in Profile, Census 86, ABS), one in five were born overseas.

Among the 80 respondents, the number born in Australia outnumbered those born overseas by 2:1. (Table 3.3). Some idea of the heterogeneity of the sample is provided by identifying the different regions from which the overseas

born came. In Table 3.4 Australia is included in the Pacific region. In addition to the 51 Australians, three others were born respectively in Tonga, New Zealand and Indonesia. Of the 51 respondents born in Australia, 43 were born in urban or country New South Wales. In the European region, nine were born in England and one in Wales. Respondents from Asia, included two born in India, one in Sri Lanka and one in Cambodia. The sole South American respondent was born in Chile. In the European group, there was one born in Yugoslavia and Holland respectively, two were born in Hungary, Poland and Italy respectively and three were born in Russia.

Table 3.3: Australian and Overseas Born Respondents

Regions of Origin	Male	Female	Total
Australian born	15	36	51(64%)
Overseas born	9	20	29(36%)
Total	24	56	80 (100%)

Table 3.4: Regions of Origin of Respondents

Regions of Origin	Male	Female	Total
Asia	2	2	4
Europe	4	7	11
Britain	3	7	10
South America	-	1	1
Pacific	15	39	54
Total	24	56	80

Respondents' Accommodation and Income

The following tables give a picture of the respondents' accommodation and income as of January 1988. The largest number of people had mortgages and the remainder were paying rents.

In terms of income, the largest single group (16) was concentrated in the $250-$340 p.w. bracket. Three female respondents said they received no income, and four male respondents were represented in the $450+ income group (Table 3.6).

As assessed in 1988, these weekly incomes were low, with as many as 27 respondents (34%) living around subsistence level. Although not exclusively poor, the respondents were struggling to make ends meet. Those paying mortgages were using a disproportionate amount of their income for their accommodation. For example, 32 people (40%) were spending more than 40% of their total income on their mortgages. Those who were in subsidised Housing Commission accommodation also had little money left over after paying for their rent. They were living near the margin on either Social Security or other very low incomes.

Table 3.5: Means of paying for accommodation.

	Male	Female	Total
Renting	7	19	26
Mortgage	9	23	32
Owned Home	8	12	20
Other	-	2 1 at home 1 in nursing home	2
Total	24	56	80

Table 3.6: Respondents' Income

	Male	Female	Total
No Income	-	3	3
$150 pw	3	15	18
$150 - $240 pw	4	12	16
$250 - $340 pw	6	16	22
$350 - $440 pw	7	10	17
$450 + pw	4	-	4
Total	24	56	80

When did the migrant respondents come to Australia?

Over the years, there have been major changes in the mix of countries of origin of people arriving to settle in Australia. The respondents in this sample showed some of these trends. Those older 'new Australians' who arrived in the 1950's and 1960's came mainly from Britain and other European countries. In this sample, all the respondents of European birth had been resident in Australia for 25 years or more, the one exception being a 23 year old woman who was brought to Australia from Italy as a two-year old. Of the more recently arrived 'new Australians', the middle-Eastern and Asian groups predominated, a trend reflected in this sample. Although there were no respondents from the Middle-east, there were four respondents from Asia.

The 1986 Census statistics showed a cluster of middle-Eastern and Asian people in the three local government areas. One would have expected a higher proportion of these respondents to have experienced depression. Why were there so few non-English speaking migrants (NESB), especially the most recently arrived ones found in this sample?

Language barriers and hesitancy in talking about one's experiences were probably the main reasons why more NESB migrants did not respond to this research. For example, communication about depression is difficult and doubly so if one's command of a language is poor. Since the initial interviews, letter and my subsequent research interview, were conducted in English, it is almost certain that people who were not competent or confident in their spoken English would have been excluded. Cultural constraints affected respondents' willingness to reveal such a personal experience. Uncertainty about how the host culture perceived depression probably deterred another pool of potential respondents. In these respects the number of migrant respondents is somewhat surprising. Two migrant women did explain why they were initially hesitant about participating in this research and why they eventually decided to respond. A 42-year old Chilean women who was widowed by the suicide of her husband shortly after arriving in Australia said:

> I thought it might help other people if I tell my story to you. I trust you as you are from the university. Maybe other migrants have felt guilty because they don't like the country, feel sad to leave their country, only get dirty jobs even if we are qualified and get called bad names. Starting life again in another country is not easy.

Another migrant, a 45-year old Indian woman, married to an Englishman and with one daughter aged 14 commented:

> I decided to come forward and tell you about myself. It's probably easier for me because I have the language but I think others might come forward too, if they could. Many people are shy. It's not easy being a migrant, especially when you look and sound different, especially when you look and sound different, maybe it's time Australians appreciated that we have feelings too.

In summary, the respondents who identified themselves as having been depressed in the past year, were heterogeneous in terms of age, resources and circumstances. There were some who lived in comfortable homes and had adequate material resources. A few said they enjoyed a comfortable life-style even though they were depressed. Most were finding life a very considerable struggle financially. These included respondents who were renting accommodation at high rates or lived in small Housing Commission homes and had very little in the way of material comforts. What they all had in common was the experience of depression.

The Doctor Respondents

Twenty general practitioners were interviewed. A profile of this group of doctors follows (Table 3.7).

Table 3.7: Doctors' Age and Sex

	25-34	35-44	45-54	55-64	65-74	75+	Total
Male	1	4	4	3	1	1	14
Female	5	1	-	-	-	-	6
Total	6	5	4	3	1	1	20

The youngest doctor was a 28-year old female and the oldest a 79-year old male. All the women doctors except one were in the 25-34 age group. There was only one male in this group. Just over half the male doctors were in the two age groups, 45-54 and 55-64. These age ranges probably reflected some differences in medical training, a topic pursued in Chapter 10.

Did the doctors work alone, in partnership or in groups?

This sample showed a range of ways to organise general practice. There were doctors who had a solo practice, some were in partnerships and others in group practices of three or more. The following table shows this range of practice arrangements.

Table 3.8: Type of Practice

	Solo Practice	Partnership	Group Practice
Male doctors	8	4	2
Female doctors	-	5	1

Just under half of the doctors in this sample (all male doctors) had solo practices. Five of the six female doctors practised in partnerships. Only two female doctors were partners in the partnership in which they worked. The other three were what one of them called 'hired hands'. One of these was a locum doctor and the other two had a part-time arrangement with their employing doctor colleague. For these two women, this arrangement was convenient, as they had children and only wished to work part-time. By contrast, all the male doctors were equal members of a partnership: they were not 'hired hands'.

Four of the eight doctors who worked alone reported that, at times, they experienced a sense of loneliness which arose from not having a fellow colleague with whom to discuss 'difficult cases' and no sense of immediate support should it be needed. As one established and confident doctor in his early 40's said:

> Sometimes it would be good to check something out. Not having another doctor on the premises means I have to rely totally on myself. It's not that I can't take the responsibility or I don't feel competent - just that, sometimes, it would be cheering to have an immediate second opinion or to get some feed-back and support.

Doctors reported themselves working constantly at patients' beck and call, and even at a 'crippling pace'. They complained about the demoralising effect of poor physical surroundings on themselves. Two of the doctors who practised alone worked in small, confining rooms and one had a receptionist working for only a quarter of the advertised surgery hours. This doctor said:

> It can get very claustrophobic in here. Seeing patient after patient, hour after hour, listening to never-ending complaints can be difficult. I have my good days and my bad days. It does get lonely and sometimes frustrating. Having a partner to bounce a few ideas off would be welcome. But I'm due to retire shortly so I'll see it out this way.

This doctor had been in the same practice for 40 years. He had begun in a partnership, but for the past 20 years he had worked alone.

The doctors in partnerships reported satisfaction with this arrangement. It gave them flexibility. They were able to take time off and share patient loads when another partner was on leave. Potentially, at least, professional and personal support came in a partnership.

For the two doctors in group practices, there were benefits as well as tensions. One doctor worked in a four-person practice and the other in a three-person practice. Both doctors reported that there was support and back-up in those contexts, but that there was more possibility of 'personality clashes' than in a partnership. The three-person practice had previously been a four-doctor practice, but the fourth doctor had left allegedly on account of years of personal differences. Sharing power in group practices provided attractions and problems. One doctor said:

> It can be difficult and tense when all of us get together to make decisions. We're all meant to have equal say, but it's a bit like the motto in Animal Farm - all animals are equal but some animals are more equal than others. It's the same here. Most of the falling out occurs over power issues.

Theoretically, there were advantages and disadvantages in all three modes of practice, solo, partnership and group practice arrangements. In this particular sample, however, the most content group of doctors were those who were involved in partnership arrangements. The reasons for this seem to involve both professional and personal issues. A partnership arrangement offered flexibility and support and an accompanying possibility of minimum tension between the partners. The danger of loneliness was diminished, the tangibility and accessibility of support maximised and the probability of conflict minimised. However, even under this sort of arrangement there was potential for problems to develop. Several doctors in partnership arrangements spoke from their own past experience or second hand knowledge about the potential risk of their partners developing a 'bad attitude' or having personal problems which resulted in poor personal and professional performance. One doctor recounted what he called a 'horror story' relating to a friend's experience. That friend, also a G.P. found that his partner, with whom he had worked for 10 years, became emotionally unstable after a messy divorce. Subsequently, the partnership arrangement became untenable, a result which could not have been predicted when they went into the practice.

Doctors and ethnicity

The following tables show the proportion of Australian trained to overseas trained doctors and the specific countries in which the doctors completed their initial training.

Table 3.9: Australian vs Overseas trained

Where Trained	Male	Female	Total
Australia	7	4	11
Overseas	7	2	9
Total	14	6	20

Just over half of all the doctors in this sample were trained in Australia. This training refers to initial medical (undergraduate) training and does not include higher degrees or 'make-up' courses that doctors are required to complete to be accepted in Australia as medical practitioners. The next table (3.10) shows where each doctor received his or her initial degree.

Table 3.10: Country in which initial training received

Country	Male	Female	Total
Australia	7	4	11
United Kingdom	2	-	2
Hong Kong	1	1	2
Argentina	1	-	1
Russia	1	-	1
Poland	1	-	1
New Zealand	-	1	1
South Africa	1	-	1
Total	14	6	20

All the doctors spoke English well, and all the foreign trained doctors spoke a second language. One Australian trained doctor (of Italian descent), spoke a second language, Italian. The country in which the doctor trained does not necessarily reflect his or her ethnicity. For instance, of the two doctors who trained in the United Kingdom, one was Sri Lankan and the other Indian.

An interesting, almost predictable feature in the relationship between doctors' ethnicity and their clientele, was that they tended to attract patients from the same ethnic group. For instance, I was told by one Russian female respondent who was depressed, that she and all her Russian acquaintances always consulted the Russian general practitioner whom they all 'trusted'. His speaking their language facilitated their feeling at ease with him. In addition, he was said to 'remember the old ways and to respect things we believe'. Cultural ties were important. They gave the comfort of familiarity. They legitimated a doctor's authority. A slightly different interpretation was given by an ethnic Chinese doctor who said that more than half his patients were Chinese, even though the

suburb in which he practised was not immediately identified as being heavily populated by this ethnic group. He said he believed he attracted the Chinese patients because many of them were desperate to identify with 'old ways' and liked to think a Chinese doctor 'really understands'. This doctor said that often his Chinese patients made a pretence of wanting 'traditional Chinese medicine, but they really want to be talked into taking some Western medicine as well!' He believed he was in the ideal position to influence such patients as they would not accept treatment so readily from someone 'without the right sort of eyes'. He laughed at this explanation. He also emphasised trust: ethnic patients trusting ethnic doctors and the same doctors understanding the trust invested in them and the influence they held.

This chapter has described the background of the sample but provided only glimpses of the life of an individual respondent. A more detailed picture of the nature and extent of depression was obtained from the respondents' answers to the Zung Self-rating scale and some idea of the social problems which were experienced by them emerged from an analysis of responses to the social problems inventory. The use of these two instruments as a means of 'assessing depression' is described in the next chapter, which has as its sub-heading, 'clinical and social criteria'.

CHAPTER 4
ASSESSING DEPRESSION: CLINICAL AND SOCIAL CRITERIA

Instruments for measuring the nature and severity of depression, in terms of affect, symptom or disorder, have included questions about individuals' state of mental and physical well-being. Whether these instruments were administered by professional clinicians, as in the Hamilton Rating Scale for Depression (Hamilton 1960) or were self administered (Beck et al 1961, Zung, 1965), a purpose and consequence of their use has been common. The investigators saw a clinical problem and were making an assessment with a view to developing an appropriate clinical response.

The reliance on these scales and instruments produces two kinds of problems for the researcher who wants to unmask the social contexts of depression. Those instruments have an impressive record of measuring the existence and seriousness of depression; and an enquiry which did not use them would have to face the accusation 'how do you know that what you are seeing is merely unhappiness and not depression?', or, more specifically, 'you have not used a well tested instrument'.

The second problem derives from the first. If you use only the inventories of psychologists, psychiatrists and other clinicians, there is no chance of observing social conditions or of taking seriously a depressed person's point of view.

To address these problems, the Zung self-rating scale was used in association with a self-administered social problems inventory (Corney and Clare, 1985). The results from these two measures were then compared. This comparison was the prelude to an analysis of information which came from respondents' first-hand accounts of their experiences.

Each step was taken towards the goal of understanding the social context of depression. Step one required the adoption of commonly accepted clinical measures and step two required the combining of these measures with a well tested social problems inventory. Step three was to develop a typology which would be sensitive to social issues and be useful in developing thinking about treatment. Such a typology would not be dependent on the medical and psychological modalities referred to already. This thesis mostly revolves around the analysis addressed in step three. The remainder of this chapter is about steps one and two.

The Zung Scale

The Zung Self-Rating Depression Scale (ZSDS) was used at the end of interviews with a view to obtaining some idea of the nature and extent of each respondent's feeling of depression at that time. It was intended to be and it has proved useful as a baseline of measures from which to develop other insights. The ZSDS is regarded as having the following advantages. It is all inclusive with respect to symptoms of illness. It is short and simple. It is quantitative rather than qualitative. It can be self-administered to indicate the patient's own response at the time the scale was taken (Zung, 1965, p 63).

The questions used in the Zung scale measure feelings, physiological and psychological reactions. Answers to 20 questions are scored on a range of 1 to 4 with '4' being indicative of considerable depression and '1' showing less depression. Zung wisely explained:

> In using the scale, the patients were asked to rate each of the items as to how it applied to them at the time of testing, in the following four quantitative terms: a little of the time, some of the time, good part of the time, or most of the time. The ZSDS is constructed so that the less depressed patient and his complaint will have a low score on the scale, and the more depressed patient and his complaint will have a higher score.
>
> (Zung, 1965, p 64)

The raw scores are then converted to an index or scale which shows the range of severity of depression experienced by this sample. For example, a raw score of 79 out of a possible score of 80 produces a rating of 0.99. A score of 21 out of a possible score of 80 produces a rating of 0.26. The .20 index shows the lowest rates of depression (some clinicians would say that such a low score would indicate no evidence of depression), and the .9 index shows severe states of depressive illness.

The Zung scale was self administered by 76 of the 80 respondents in this study. Of the four who did not respond, three said they preferred not to make such judgments of themselves and one respondent only answered a few questions. Her incomplete return could not be used. Of the 76 who answered the questionnaire, there were no respondents in the .90 range, indicating severe depression, and only one respondent in that .20 range which indicates the barely depressed category. The distribution of scores in relation to the gender of the respondents is shown in Table 4.1.

Table 4.1: Depression Scores by Sex

Zung Score Range	Number of Respondents by Sex			
			Male	**Female**
.80	6	(8%)	3	3
.70	17	(22%)	4	13
.60	27	(36%)	8	19
.50	16	(21%)	4	12
.40	6	(8%)	3	3
.30	3	(4%)	2	1
.20	1	(1%)	-	1
TOTALS	76	(100%)	24	52

Of the six respondents in the .80 percentile, Table 4.1 shows three men and three women. In the .60 percentile, within which the largest number of respondents fell, there were 8 men and 19 women, reflecting the 1:2 ratio of men to women in the sample as a whole.

In a separate piece of analysis, the distribution of Zung scores by age range was also completed. For example, the .70 percentile included 17 respondents who were spread evenly throughout the different age bands. The largest number of respondents, 24, fell in the age band 35 to 44. The 24 in this age group were spread in normal curve fashion from the .80 to the .40 percentiles: there were 2(.80), 5(.70), 10(.60), 5(.50) and 2(.40) respectively in those five categories.

There was nothing in the distribution of Zung scores to indicate any relationship between severity of depression and the demographic variables, gender and age. Nothing could be depicted concerning vulnerability to depression merely according to respondents' age and gender. For example, although there was a higher proportion of men, 3 out of 24 (12.5%) than women, 3 out of 52 (5.4%) in the .8 percentile, in the .7 range there were only 4 men out of 24 (16.6%) by comparison with the 12 out of 54 (22.2%) who were women. Nothing could be predicted from the respondents' gender and age and even in retrospect no pattern emerged with respect to these variables.

Social dimensions of the Zung rating

It would be misleading to record the Zung scores as though they registered only a numerical score of respondents' mental health and said nothing about the social dimension of people's lives. The 20 questions which constituted the Zung scale included some questions which showed how respondents felt about themselves in relation to others and some questions which indicated something about social contexts. For example, question 19 asked for a response to the statement, 'I feel that others would be better off if I were dead', and question 18 asked for a response to the statement 'my life is pretty full'. These questions and others like them suggested that social/psychological issues and not physiological or psychological criteria alone were the major manifestations of depression among this group. This point can be explained by returning to the technique for scoring such items on the Zung scale.

In that scale, a score of 4 would be recorded if respondents said that 'a little of the time' or 'most of the time' certain things happened or specific feelings occurred. For example, if a respondent answered the statement 'I still enjoy sex'

with a tick in the 'a little of the time' column this was marked as '4'. If a respondent answered the statement 'I am more irritable than usual' with a tick in the 'most of the time' column, this was also marked as '4'.

There were areas of respondents' lives in which they were not coping well and there were other areas in which they seemed to be rating their feelings and behaviour as relatively normal. For example, 29 respondents said that only a little of the time did they still 'find it easy to make decisions' (question 16 on the Zung scale). By contrast questions about physiological changes, such as those concerning weight loss, constipation and heart rate (questions 7, 8 and 9) did not throw up the symptoms indicative of depression, at least not in this sample. The areas in which respondents 'were not coping well' concerned their relationships with others and their responses to specific features of their social environment. To substantiate this point the idea of depression being represented by the notion 'impaired social functioning' is foreshadowed by picking out those items on the Zung scale which were indicative of depression in more than 30% of the respondents' answers (Table 4.2).

Table 4.2: Highest scoring items in Zung self rating scale

Items in Zung Scale	No of time scoring '4'	As a percentage of the total
1 Feel downhearted and blue	9	11.8%
2 Morning is when I feel best	23	30.2%
3 Have crying spells or feel like it	4	5.2%
4 Have trouble sleeping at night	19	25.0%
5 Eat as much as I used to	21	27.6%
6 Still enjoy sex	20	26.3%
7 Notice I am losing weight	3	4.0%
8 I've trouble with constipation	6	7.8%
9 My heart beats faster than usual	5	6.5%
10 Get tired for no reason	8	11.5%
11 Mind as clear as it used to be	24	31.5%
12 Find it easy to do the things I used to	32	42.0%

Table 4.2: Highest scoring items in Zung self rating scale Continued:

Items in Zung Scale	No of time scoring '4'	As a percentage of the total
13 Restless and can't keep still	17	22.3%
14 Feel hopeful about the future	30	40.0%
15 More irritable than usual	9	11.8%
16 Find it easy to make decisions	29	38.0%
17 Feel I am useful and needed	27	35.5%
18 My life is pretty full	23	30.2%
19 Others better off if I were dead	5	6.5%
20 Still enjoy the things I used to	22	29.0%

In answer to question 14, 30 respondents (40%) said they felt hopeful about the future 'a little of the time'. Such a response indicated a fatalism and powerlessness which had already been elaborated in the unstructured interviews, but could now be quantified for the sample as a whole. The same process of making connections between individual responses and sample scores and vice versa can be made with reference to other questions. For example, as many as 32 respondents (42%) said that they found it 'easy to do the things I used to' (question 12) a little of the time and 27 respondents (35.5%) gave the same response to the statement that they felt 'useful and needed'.

Other questions which suggested something about the impaired social functioning of a large proportion of the sample included question 16 which depicted 29 people (38%) saying that it was only easy to make decisions a little of the time, or, conversely, that most of the time it was difficult to make decisions. Perhaps related to this point, though it does not refer to exactly the same respondents, was question 11 which had 24 respondents (31.5%) saying that their minds were only as clear as they used to be a little of the time.

It would be inappropriate to ignore questions which did suggest difficulties in terms of physiological reactions, over sex (question 6), eating (question 5) and sleeping (question 4), but the answers to these items give few clues as to issues such as social networks or social isolation. By contrast, 23 respondents (30.2%)

said their lives were 'pretty full' only a little of the time and only 22 (29%) said they still enjoyed the things they used to.

It is impossible to predict the constraints which were symptomatic of depression but this brief appraisal of answers to the Zung statements gives some clues. A large proportion of respondents did not find it easy to do the things they used to and were indecisive. A large proportion were not hopeful about the future, were not leading lives that were very full and seldom felt they were useful or needed. The actual social problems and social conditions which were associated with these feelings, or which gave rise to them, can now be spelled out by reference to the social problems inventory. This was the instrument devised by Corney and Clare (1985), which respondents were asked to complete after they recorded their replies on the Zung scale.

Incidence of Social Problems

A self-report questionnaire to identify social problems has been described as an important addition to the observations and judgments of interviewers and has been found to be 'readily acceptable to general practice patients, psychiatric out-patients and social work clients, as well as the general population'. (Corney and Clare, 1985, p 644). This particular instrument, the Social Problem Questionnaire (SPQ), was developed in pilot studies of consecutive attenders at several surgeries in a group general practice in inner London and one in outer London (Corney et al, 1982). Most of these attenders had found no difficulty in completing it and on the questionnaire they had identified social problems which were unknown to practitioners such as social workers (Corney and Clare, 1985).

The Corney and Clare Social Problem Questionnaire was selected for use in this study of Sydney respondents on account of the ease with which it could be administered and its apparent success in detecting social problems. The 80 respondents were usually asked to fill out this questionnaire after they had completed the Zung self-rating scale. In some cases the interviews began with the interviewer discussing the social context of their lives by rating the items in this questionnaire. Whatever place in which it was administered, whether at the beginning or end of an interview, it was regarded as a source of information which

would be additional to the data and insights derived from interviews and scores on the Zung scale.

The SPQ asked respondents to rate their circumstances, their management of them and their satisfaction with regard to nine areas of their lives: housing; work; financial; social contacts; marriage and relationships; domestic life; legal matters; problems of living alone; other. This last miscellaneous category was introduced with the question 'Do you have any other social problem or problems?' In answer to this question, respondents were asked to select one of four ratings: 'no problems', 'slight problems', 'marked problems' and 'severe problems'. The same four ratings were used in relation to the questions in the other eight areas.

Analysis of the respondents' replies was aimed at obtaining a picture of the incidence of social problems and an understanding of the respondents' ability to manage in their particular social environment. For example, all of the first seven sections of the questionnaire asked questions aimed at revealing respondents' degrees of satisfaction, as in the question posed to women with a full- or part-time job outside the home, 'How satisfied are you with working and running a home?' In response to this question respondents could choose one of four ratings: satisfied; slightly dissatisfied; markedly dissatisfied; severely dissatisfied.

In analysing the respondents' ratings, the major objective was to obtain an idea of the number and types of problems. It was assumed that if respondents rated themselves as having 'marked' or 'severe' problems, for my purpose this would result in recording one social problem. I was not interested in counting the number of marked versus the number of severe problems. Such an exercise would have amounted to splitting hairs. Neither was I interested in analysing the number of areas in which respondents said they were 'satisfied' or 'slightly dissatisfied', had 'no problems' or 'slight problems'. For the purpose of obtaining a picture of the number and types of problems, the categories 'satisfied', 'slightly dissatisfied', 'no problems', and 'slight problems' were discounted.

Seventy-eight respondents replied to this section of the study. These 78 included the 76 who had replied to the Zung instrument plus one who said she did not mind what she perceived as the less personal questions about social problems

(as compared to the highly personal Zung scale) and one other respondent whose replies to the Corney-Clare inventory could be analysed but whose Zung ratings had been incomplete.

The technique of using the ratings 'severe' and 'marked' as indicative of the existence of social problems produced a total of 380 problems for the sample as a whole. This total number was not spread evenly across the sample. Seven respondents said they had no marked or severe problems but one respondent identified 24 problem areas. In this range of 0-24, the mode, ie the most commonly occurring number of problems was 4, which was recorded in 11 cases (Table 4.3) By contrast, very high recordings of social problems seemed atypical: references to 24, 19 and 15 problems were only made in single cases. References to 12, 11 and 9 problems were made in only 2 cases each (Table 4.3).

Table 4.3: Incidence and Frequency of Social Problems

Incidence of Problems	Frequency	Total Number of Problems
0	7	-
1	9	9
2	10	20
3	7	21
4	11	44
5	7	35
6	9	54
7	3	21
8	3	24
9	2	18
10	3	30
11	2	22
12	2	24
15	1	15
19	1	19
24	1	24
TOTALS	78	380

The nature of the problems recorded by the sample is not indicated by number or frequency. But the number of social problems experienced by an individual is likely to be indicative of their ability to cope and could be associated with depression. With a view to pursuing this question the relationship between the Zung and Corney-Clare scores can be established. Once that part of the analysis is complete, an unravelling of data from the social problem questionnaire will be resumed.

Depression and Social Problems

In the following analysis of the relationship between the respondents' depression scores and the number of social problems which they recorded, the sample will again be 76. The three social problems recorded by the two respondents who answered the social problems questionnaire but not the Zung ratings accounts for the total of 377 problems (Table 4.4) rather than 380.

Table 4.4: Social Problems and Depression Scores

Zung Range	Number of Social Problems	Number of cases	Average no of Problems	Range
.80	50	6	8.3	2-20
.70	136	17	8.0	2-24
.60	121	27	4.5	0-11
.50	51	16	3.2	0-14
.40	16	6	2.6	1-04
.30	3	3	1	0-03
.20	-	1	-	-

High scores on the depression rating scale were associated with a large number of marked or severe social problems. For example, in the .80 percentile range the six respondents recorded an average of 8.3 social problems. By contrast the six cases in the .40 range recorded an average of only 2.6 social problems.

There was little to distinguish the cases in the top two percentiles in terms of the total and average number of problems. But there was a considerable contrast between the apparent experiences of the 23 cases in the categories of most severe depression and the rest of the sample. The average of over eight social problems per individual was almost twice as great as that experienced by the sample as a whole and approximately four times the average of social problems recorded by respondents who fell into the .60 percentile range and below.

At this point in the analysis it is tempting to pursue an investigation of respondents in terms of the association between high scores on the Zung and Corney-Clare instruments. But to do that is to assume that these instruments alone could portray the social context of depression. This would still leave unanswered questions, such as what did these social problems mean to different respondents, what impact did a problem have on someone, how long did that impact last and what form did it take? Table 4.4 does suggest that a higher than average incidence of social problems was experienced as stressful, in many cases as intolerable, and was reflected in severity of depression and vulnerability to depression. Table 4.4 also suggests that a small incidence of social problems would suggest that if depression was experienced it would not be severe, or, put another way, that vulnerability to depression would not be high if the incidence of marked or severe social problems was low. These last points return us to an analysis of the social problem questionnaire with a view to identifying which areas of life were experienced as social problems and how these problems were distributed across the nine categories.

Types of Social Problems

In answers to the Social Problem Questionnaire the spread of social problems identified as either marked or severe, is given in Table 4.5 'Social Problems by Area'. In the nine areas under which the questions about social problems were organised, more questions were posed about some areas than about others. There were five questions about 'relationship difficulties' and six questions about 'domestic life', a reference to responsibilities for children and close association with other adults. It is probable that the number of problems in a particular area would vary according to the number of questions asked, an

hypothesis which seems to hold true with regard to 'relationship difficulties' which was referred to 77 times. But the questionnaire used several questions to probe respondents' experiences in this area of their lives and there were separate questions for those who had 'steady relationships' and for those who did 'not have a steady relationship'.

With a view to calculating the problem areas which occurred most often, I have avoided putting much emphasis on aggregates, such as 77 in the case of 'relationship difficulties', 59 in the case of 'financial circumstances' and 48 in the case of 'work'. Instead, I have recorded the number of questions which were used in a particular area (ie in the SPQ) and divided that number into the aggregate for a problem area. For example, there were 37 references to severe or marked problems with housing but only two questions which elicited these responses. There were 62 references to severe or marked difficulties with social contacts but as many as five questions used on this topic. This produces an average of 18 references to housing related difficulties and an average of 12 references to social contacts (Table 4.5).

Table 4.5: Social Problems by Area

AREA (as referred to in Questionnaire)	No of times referred to as 'marked' or 'severe'	No of questions eliciting responses on this topic	Average no. of references to this problem area
A Housing	37	2	18
B Work	48	4	12
C Financial Circumstances	59	4	12
D Social Contacts	62	5	12
E Relationship Difficulties	77	5	14
F Domestic Life (Children and Other Adults)	29	7	4
G Legal Matters	2	1	2
H Living Alone	25	2	12
I Other	37	1	37

Given that the social context of depression might be depicted by the relationship between these different areas and by the connotation which marked or severe problems had for different respondents, only a little time need be spent in examining any one area. I say this because it was relatively easy for respondents to place a circle around an answer in a structured questionnaire, yet much more illuminating to hear their first hand accounts. Those accounts will be discussed later with reference to experiences in three broad areas: work, relationships and social conditions.

Questions about housing and finance will be subsumed in that general area, 'social conditions'. In that respect the respondents in this sample showed a high degree of dissatisfaction with their housing. Reference to 37 problems with housing was made by 21 respondents, ie some respondents answered 'marked' or 'severe' to different housing questions.

To the question, 'how satisfied are you with your financial position?', 23 respondents said they were markedly or severely dissatisfied. A majority of those 23 also had the scores in the .80 and the .70 range on the Zung scale. Seventeen of the respondents with financial difficulties had also referred to housing problems: they felt stuck in accommodation which they did not like and they had no financial means of improving their circumstances. However, the difficulties with social conditions proved to involve more than financial and housing difficulties though these were fundamental issues.

Separate questions addressed individuals' dissatisfaction with their work and with unemployment. For example, 15 respondents were markedly or severely dissatisfied with their employment but another 12 were markedly or severely dissatisfied with their lack of work. This referred in most cases to unemployment but there were also several retired people who felt that they had never been able to make the transition from full-time employment to retirement.

Of those who were markedly or severely dissatisfied with their employment only three were women. Given that men represented less than one-third of the sample, the importance of work related issues to men's sense of depression is apparent. That point does not rule out the importance of work related issues in

the lives of the women who were depressed. Unable to find work, or dissatisfied with uninteresting or poorly paid jobs, women as well as men were left with a sense of not being in control of their lives. It was not only lack of control but also its corollary, - a sense of being controlled by others, which appeared to contribute to depression. These themes will reappear in the discussion of the meaning of 'impaired social functioning', but another work-related topic also merits more attention. This concerns the relationship between financial and work problems.

In the Australian Social Security Review of 1987/88 the relationship between poverty and unemployment was clear (Cass, 1988). Unemployment and low wages were closely associated with poverty. With this link in mind, the relationship between financial problems, employment difficulties and depression needed to be explored by recording the numbers who were markedly dissatisfied with their financial position (Q.10 on the SPQ) with those who were markedly or severely dissatisfied with not working (Q.7). Of the 15 respondents who were either unemployed or dissatisfied with their wages and conditions, nine reported themselves as also having severe financial difficulties.

The area of relationships and social contacts, or rather the lack of them, produced perhaps the greatest sense of dissatisfaction. For example, with regard to the specific question of social contacts, 29 out of 76 respondents said they were markedly or severely dissatisfied with the amount of time they were able to go out. Evidence of apparent social isolation was confirmed in terms of the high proportion of individuals who expressed dissatisfaction with the absence of a steady relationship in their lives. Twenty-four out of 76 were markedly or severely dissatisfied with not having a steady relationship. The value placed on relationships was apparent when the answers to this question were analysed by excluding those in the sample who were already part of a 'steady relationship'. For example, if those who were married or cohabiting were excluded, there were 41 people for whom the absence of a steady relationship might have been a pertinent factor associated with depression. Of these 41, 23 (61%) regarded the absence of a steady relationship as a marked or severe problem.

The notion 'steady relationship' was perceived as having important qualities in terms of having someone who might be loved as well as trusted. The importance of such qualities in a relationship was also expressed, albeit in a negative way, by respondents who were married. For example, of the 34 respondents who were married or cohabiting, 16 said they had marked or severe difficulty confiding in their partners. Half of these 16 also maintained that they had marked or severe sexual problems in their relationships. Prima facie there seemed a highly plausible link between difficulties in confiding in partners and the absence of a satisfying sexual relationship.

Overall, the answers to questions about relationships and social contacts showed the importance of satisfying personal relationships in the lives of men and women, married and the unmarried. For example, 14 of the 24 men had either no satisfying steady relationship, or, if they were married, they also felt that their relationship with their partner was not satisfying. Twenty-six of the 54 women gave the same or similar answers.

The problem area referred to as 'other' produced 37 severe or marked difficulties. Respondents were asked to specify these 'other' problems and their answers depicted the relationship between accommodation, health, financial and relationship difficulties. That interdependence was apparent when they described the accumulation of experiences which had contributed to depression. For example, a 58-year-old Cambodian refugee whose wife and children had been killed following the invasion of that country by the Khmer Rouge said that his 'other severe problem' was 'a longing for my country. I want to return to my country one day.' Another expression of nostalgia for what had been and what might be was described by a 39-year-old woman with a 10 year old son who was separated, who wanted to be slim again and who referred to her obesity and compulsive eating as being tied up with her financial difficulties. 'I'm unhappy, I don't seem to be able to afford to be otherwise. To put off thinking about it I eat.'

A common denominator in the examples of 'other' problems was the references to physical and mental health. The absence of good health, or of a feeling of being unwell, gave a sense of lacking control. A 17-year-old single girl who lived with her parents and felt isolated from her peers said that 'other'

problems included 'not only anxiety about my weight and difficulties in sleeping but also worrying about going mad, ... breaking down again, I might not come out of it next time'.

The combination of feeling out of control due to pressures associated with ill health and being controlled by others was expressed by a 31-year-old woman with two children. Meredith explained how her monthly fits of depression associated with extreme pre-menstrual tension and pain were 'caused' not only by difficulties in caring for a hyperactive child but also by a mean and greedy landlord. She said:

> The extra problems are extra to coping with a kid I couldn't cuddle. The rents are getting out of hand as much as my period pains do. The floor boards are going, the toilet needs fixing but the landlord has us over a barrel. He's a touchy little person. He won't fix these problems. I can't fix the others.

Table 4.5 also shows those areas of life which did not produce severe or marked difficulties. For example, only three out of 76 complained of having problems with neighbours and only two respondents identified legal problems. Only five respondents referred to problems in coping with children under school age. At least with regard to this sample, neither neighbours, legal matters nor difficulties with children had much to do with the development and onset of depression. In subsequent discussion of non-medical treatment it will be as important to know what is not associated with depression as to ruminate over what is.

Links to Social Context

Respondents' scores in relation to the depression which they had experienced within the past year and on the incidence of social problems give some idea of the meaning of depression for these people at a point in time. They experienced different degrees of lassitude with regard to emotions and ability to make decisions. They contrasted their mental state and social circumstances as worse, and in many cases far worse than previously experienced. Associated with this mental state and social circumstances were varying numbers of social

problems, and these problems appeared to be greater in number for those whose depression, as measured by the Zung scale, appeared to be the most severe. However, these figures and scores have been discussed out of context. The general question, about the meaning of the social context of depression can be addressed in other ways, for example, by depicting diagramatically the various issues which affected the biography of the people in this sample. This more general way of addressing questions about context will be addressed, in chapter five.

CHAPTER 5

THE NOTION OF 'SOCIAL CONTEXT'

In their responses to the Zung scale, the Corney/Clare inventory, and in answers to open-ended questions, respondents referred to physical signs and symptoms of depression; and a common denominator in their explanations was their accounts of deterioration in relation to where and how they lived and with whom. This where, how and with whom combination I refer to as social context.

In between the problems of the narrow picture produced by a scale and the too general collection of ideas contained in the notion social context, lies the thesis about depression being explained in terms of impaired social functioning. That thesis has been built partly on an analysis of scores in scales and by wrestling with the notion of social context. What is meant by that notion?

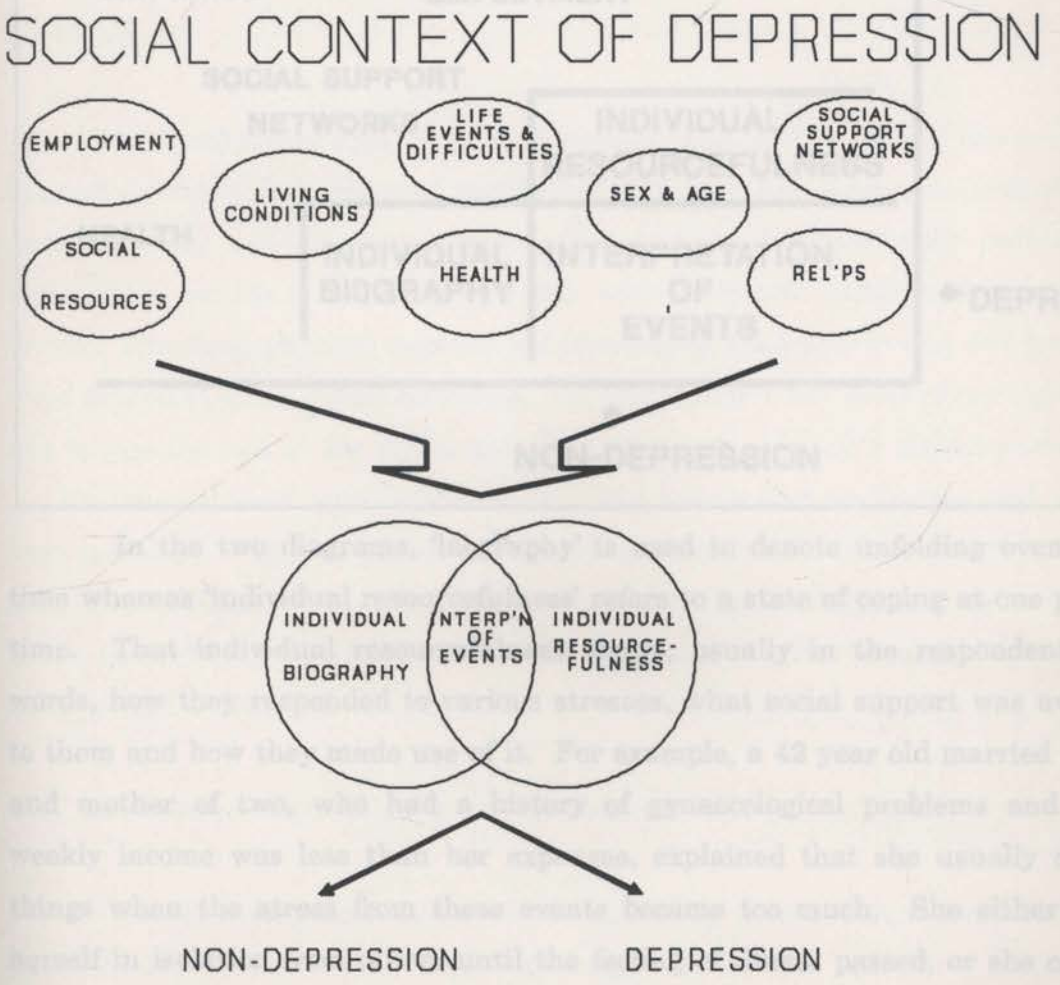
In the semi-structured interviews in the homes of 80 respondents, specific questions centred on employment, living conditions, personal relationships, health and the respondents' recall of specific life events and difficulties. How the answers to these question related to the onset and experience of depression I have reconstructed diagrammatically (Figure 5.1 and Figure 5.2).

Theoretical Perspectives

These diagrams have been drawn to show what questions might be included in an assessment of depression and thereby what considerations should be addressed in any treatment plans. The theoretical perspective used to analyse the data is reflected in that section of the diagrams which depicts the notions 'individual biography', 'individual resourcefulness' and 'interpretation of events'. These concepts illustrate individuals in social relationships constructing their view of reality, albeit in a picture pieced together by a researcher. They provide a means of showing how the different respondents could account for lives and careers affected by their experience of depression. In diagram 5.1, those concepts

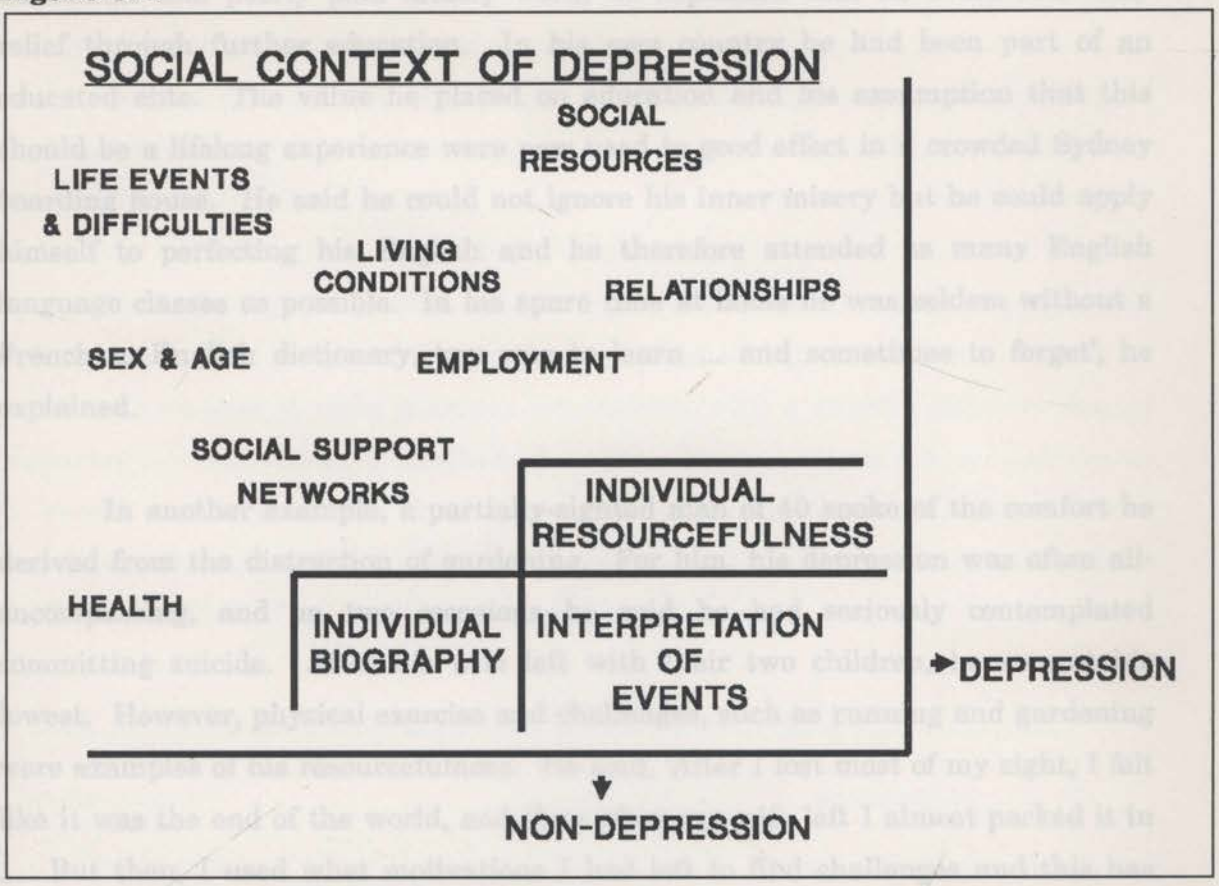
are depicted within overlapping circles. In diagram 5.2, the concepts are drawn in heavier lines partly to show that 'interpretation of events' would be the product of an unfolding personal history (individual biography) and partly a reflection of a capacity for solving problems (individual resourcefulness).

Figure 5.1:



The relationship between an overall picture of social context and the sum of specific experiences regarding health, life events, social supports, employment, living conditions and relationships depends on the filtering which occurs in terms of biography, resourcefulness and an individual's immediate consciousness. That 'immediate consciousness' was apparent to the researcher-interviewer in terms of how the respondents made sense of their lives and why they chose to emphasise some features of themselves and their lives more than others.

Figure 5.2:



In the two diagrams, 'biography' is used to denote unfolding events over time whereas 'individual resourcefulness' refers to a state of coping at one point in time. That individual resourcefulness shows, usually in the respondents' own words, how they responded to various stresses, what social support was available to them and how they made use of it. For example, a 42 year old married woman and mother of two, who had a history of gynaecological problems and whose weekly income was less than her expenses, explained that she usually did two things when the stress from these events became too much. She either placed herself in isolation from others until the feeling of illness passed, or she confided in one trusted female friend whom she had known for years. Such resourcefulness might not be sufficient to deflect the impending depression but it showed her struggling against difficult odds.

Another example of individual resourcefulness as a feature of biography concerned a middle-aged Cambodian refugee who had been a high ranking public servant in Pnom Penh before that country had been overrun by the Khmer Rouge. Without satisfying personal relationships or social contacts and employed in

unfamiliar and poorly paid factory work, he explained that he could seek only relief through further education. In his own country he had been part of an educated elite. The value he placed on education and his assumption that this should be a lifelong experience were now used to good effect in a crowded Sydney boarding house. He said he could not ignore his inner misery but he could apply himself to perfecting his English and he therefore attended as many English language classes as possible. In his spare time at home he was seldom without a French to English dictionary, 'my way to learn ... and sometimes to forget', he explained.

In another example, a partially-sighted man of 40 spoke of the comfort he derived from the distraction of gardening. For him, his depression was often all-encompassing, and on two occasions he said he had seriously contemplated committing suicide. After his wife left with their two children, he was at his lowest. However, physical exercise and challenges, such as running and gardening were examples of his resourcefulness. He said, 'After I lost most of my sight, I felt like it was the end of the world, and then when my wife left I almost packed it in ... But then, I used what motivations I had left to find challenges and this has kept me afloat.' His reference to his various means of 'keeping afloat' provided a hint about the nature of non-medical treatment, that is, initiatives taken without resort to medically trained doctors. This topic, non-medical treatment alternatives is developed at length in Chapter 12.

The Outcomes, Depression and Non-depression

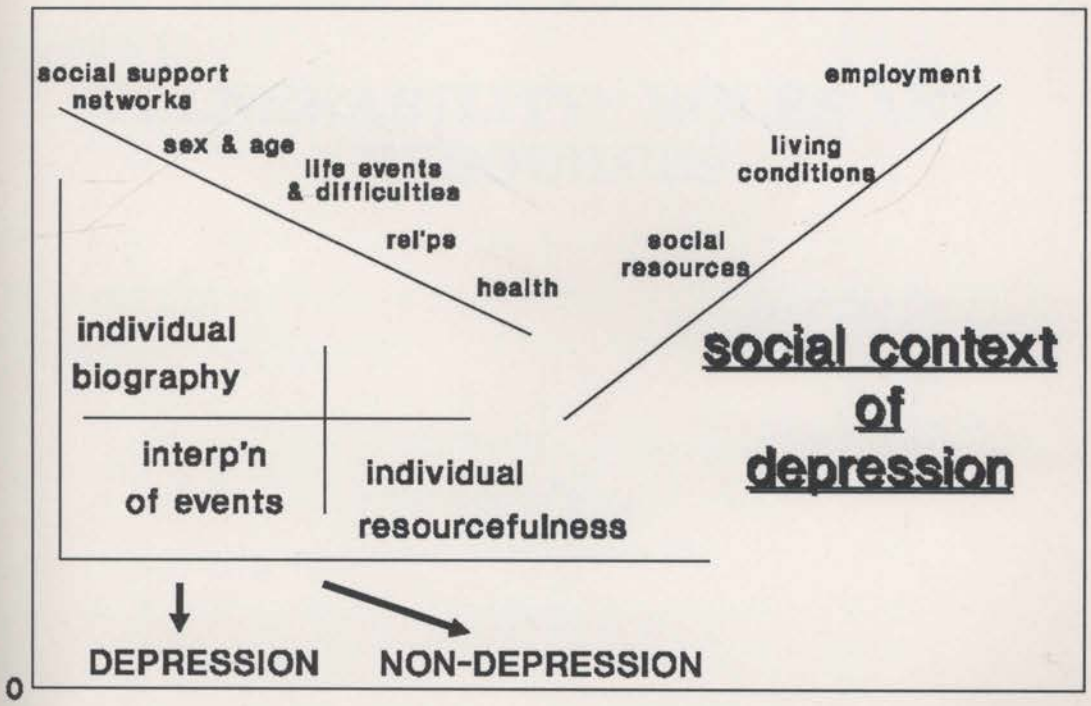
The two diagrams display two apparently discrete outcomes, depression and non-depression. This either/or suggestion is not apt if it conjures an impression of one series of events which led to depression and another which led to non-depression.

The purpose of depicting two outcomes is to suggest that, potentially, most people are vulnerable to suffering, even for a short time, from feelings of depression even if those feelings do not mature into an illness. Some people are far more vulnerable than others because internal and external pressures are greater than their resources and resourcefulness. Others may verge on the edge

of being unable to cope, yet have access to resources and can summon resourcefulness which enable them to recall that they managed somehow and were never really depressed. In this respect the two concepts, depression and non-depression, indicate different patterns of life events and capacities for coping with them.

Various ways have been used to depict the dynamic quality of people and events in context. By showing that 'social context of depression' is not marked by a line or boundary, a third diagram experiments with a slightly different way of capturing the interaction of people and events. Thus in Figure 5.3, a combination of events and biographical details, on converging diagonal lines, describes the notion 'social context of depression'; and almost simultaneously the question about the interpretation of events is located within that context.

Figure 5.3:



In the end, the diagrams will not suffice. The respondents' verbatim accounts will identify which aspects of social context were experienced as incapacitating and why. Analysis of these issues proceeds to the notion of depression as impaired social functioning, but could not have done so without pausing to reflect on the meaning of context.

Contributing and alleviating conditions

Although discussion of context has toyed with ideas about individuals' resourcefulness and interpretations of events, the use of such terms has been premature. Accounts of resourcefulness only occurred in relation to events and outcomes which appeared to have contributed to the onset of depression or in some way were insulating people from the onset of that condition. These events and circumstances appeared to be associated with experiences of work, personal relationships and social conditions. How that conclusion was arrived at and what it means in terms of impaired social functioning is the subject of the next chapter.

PART III

VULNERABILITY: ROLES AND RESOURCES

CHAPTER 6

DEPRESSION AS IMPAIRED SOCIAL FUNCTIONING

The respondents talked at length about areas of their lives in which they were very dissatisfied with themselves; with their circumstances and with others around them. In these areas they described themselves as not functioning very well. Their accounts were sometimes that literal and in other examples less direct. As the interviews proceeded, I observed that some respondents felt immobilised in some areas of their lives but not in others. I was seeing as well as hearing a picture of depression through references to social functioning, or rather to 'living below par', 'not functioning very well'. Specific explanations of the meaning of depression were apparent in statements such as 'I can't cope when I'm down', 'I can't function when I'm depressed', 'When I'm low I can't cope with things like I usually can', 'When I'm down I take to my bed and stay there till I can face the world again'.

These phrases sketched an image of the quality of these respondents' lives. Their language expressed their ideas about social functioning and their feelings of being immobilised or impaired in various contexts and relationships.

On closer analysis, I found that this notion of functioning and coping always had a 'social' dimension which involved the performance of roles. The respondents were not alluding to physical or bodily functioning. Even if, as shown in the Zung ratings, there was a physical or physiological component to their depression, there was also a social dimension as reflected in observations that some aspect of their role performance was impaired. This reference to role performance raised questions about the respondents' expectations of normal roles, and thus the standards of normality by which they were making judgments of themselves. These judgments implied statements about being sick rather than healthy, feeling unusual rather than normal. They were judgements about their depression as a deviation from some norm. Such a norm was not articulated as fixed and immutable. However, it recognized, at least implicitly, the point made by Freidson:

> What the layman recognises as a symptom of illness is in part a function of the deviation from the culturally and historically variable standard of normality established by everyday experience (1970: 285).

Respondents' descriptions of their experiences at the time when they were feeling depressed suggested an awareness of not meeting their own or others' expectations. For example, dominant values in Australian culture presuppose active and satisfying roles regarding the tasks of employees, parents and partners in relationships. This assumption about 'satisfying roles' applies in the family and in a wider social context. Yet experiences of depression impaired the chances of such active and satisfying role performance: there was a 'deviation' from the 'norm' which was culturally and historically determined. My evaluation of what represented 'deviation' or 'impaired' in relation to the 'norm' of social functioning referred to a specific event and time which was familiar to each of the respondents in this study. In this respect the following typology of impaired social functioning depicts the links between depression and a social context which was specific to the individuals concerned **and** referred in general to conditions in one part of urban Australia in the late 1980's.

My observations about impaired social functioning (ISF) came from respondents' descriptions. Some of them contrasted negative aspects of their lives with positive ones but the subsequent judgments 'positive' and 'negative' were made by this researcher. For example, expressions of dissatisfaction with personal relationships or with work-related events resulted in my marking these areas as negative in the typology. Comments that housing and related living conditions were 'alright', 'satisfactory', or 'no complaints' resulted in my marking this as positive in the typology.

Positive areas of social functioning were regarded as depicting conditions which alleviated a sense of depression whereas negative areas portrayed conditions which were regarded as contributing to depression. The adjectives positive and negative can be used interchangeably with the terms alleviating and contributing. In the interviews it was much easier to ask 'what events do you feel have contributed to your depression' than to use the word negative as in asking 'what do you feel negative about?' It is also important to stress that the respondents were not necessarily making either/or judgments: positive or

negative, alleviating or contributing. People intermingled positive with negative comments about areas of their lives such as work, relationships and living conditions but they usually showed which of those areas had contributed to or had alleviated their experience of depression. Before discussing the negative and positive connotations of work, relationships and social conditions, some observations should be made about the issue of respondents' health.

The Issue of Health

It was tempting to isolate health as a discrete feature of each person's life and to list this feature as positive or negative. This way of addressing the issue has been rejected for several reasons. Acknowledgment of depression involves a reference to ill-health. In this respect the issue for a diagnostician or for a researcher becomes, what is the relationship between a feature of health such as depression and the impact of other aspects of people's lives?

Another reason for not isolating health in a typology of impaired social functioning was that many, if not most of the respondents, talked about their health in relation to their social environment. For example, if someone had been injured at work and was thereafter too disabled to be employed, the issue of ill-health became manifest in other key aspects of that person's life. In this example as in others, various references were made to health as affecting work, relationships or social conditions. Experience of health or illness appeared to be inherent in role performance in key areas, another reason for not focussing on 'health' as a separate issue.

Comments on health were included in discussion of work, relationships and social conditions in terms of comments about well-being and self esteem. I will return to this reference to self-esteem and performance of roles because it emerges as the way in which the notion of impaired social functioning can best be expressed. At this point, however, something needs to be said about the cultural significance of work, relationships and social conditions. The social meaning and significance of these aspects of life is made up of general constructs as well as specific, localized interpretations.

Work: At different stages of the life cycle, people's social status and networks, their income, and the nature of their leisure time depend on their work. This usually refers to paid employment but could also refer to unpaid work as in the case of women at home and retirees. Respondents in this study were dissatisfied if they were unable to conform to the work ethic. This was apparent from their comments about the value of working, the enjoyment which came from work, and by the hopefulness conveyed by those who had been unemployed and had returned to work. In different ways, some element of control over a working environment was regarded as preventing or alleviating a sense of depression.

Respondents spoke of the importance of work not merely in terms of necessity but also with reference to its distinct social and psychological advantages. A 36 year old widow explained, 'I look forward to work as it takes me out of myself.' A 38 year old married woman said of her job, 'It's not much. I'm a check out chick but it gets me out and about and I like the people I work with.' A 46 year old man with a blue collar job explained, 'At work I can't dwell on my problems like I do when I am alone at home'.

Relationships: Respondents' descriptions of satisfying and dissatisfying personal relationships referred to their roles as husband or wife, as parents and in some instances as children. Some referred to friendships or the lack of them and to feelings of well being which came from being a member of a community, or to the discomfort of not being in any community. Their comments reflected a premise strong in contemporary Australia: that there were considerable benefits to be gained from conventional heterosexual relationships and associated family roles. However, it was not merely conformity to socially sanctioned behaviour which provided the motives and pleasure inherent in relationships. They also provided protection and reassurance. For example, a 52 year old woman explained, 'This is my second time around and it could not be better for me. I know that I can rely on my husband, so when things were really bad my relationship kept me going.' A man spoke of his disillusionment with his work and the way his marriage compensated.

> My strong relationship with Jan has kept my head above water. Too much has happened in my life in the past year and if it were not for this feeling of stability and security in my relationship, I don't know where I would be.

Social Conditions: Social conditions refer to individuals' appraisal of themselves in relation to their surroundings. Their positive and negative judgments were not an objective statement about a standard of living. If they had been, then people who were materially well off could have been predicted as unlikely to have suffered depression or to be living in circumstances which would have an alleviating effect following any onset of depression. Conversely, those who were living in poor material conditions would say that such circumstances contributed to depression. This was not always the case. In addition, many respondents commented on the negative effect of Australian social and economic policies in relation to their perception of 'social conditions'. They discussed taxation, health services, education policies and social security. They described the effect of these policies on their lives. For example, one migrant commented, 'I do not like the tax system in this country. It makes lawyers and accountants rich. I work hard but the tax takes too much'. More specific than comments on the effects of social policies were some respondents' accounts of their neighbourhood and community. A migrant whose wife had recently died spoke of the importance of his church and his ethnic based social club. ' The church is important. The Apia club helps a lot'.

Developing the Typology

The task of distinguishing one type of social functioning from another is as demanding for the researcher in the social sciences as it would be for a diagnostician, whether that person was a psychiatrist, a G.P. or a social worker. I make this point because, with regard to the tasks of assessment and interpretations of treatment, the role of the researcher and the task of the diagnostician has some things in common. For example, the link between research enquiry and discussing diagnosis and social treatment could be direct, if the connection is made and if the implications are developed. In that respect the categories being used to assess respondents' role performance in different areas of their lives could be applied by various practitioners to ensure that social conditions are not omitted in any diagnosis and treatment of depression.

The following classification scheme uses respondents' descriptions and this researcher's observations. It produces a typology in which three key areas of people's lives, - work, personal relationships and social conditions, are judged as contributing to depression, i.e. negative in their effects, or as likely to alleviate or prevent depression, i.e. positive in their effects.

At first glance, it might seem artificial to separate areas of people's lives and judge them positive or negative: whether they had positive (alleviating) or negative (contributing) experiences at work, in their relationships and in their social milieu. I was working towards a composite picture of each respondent's life by assembling pieces of a jigsaw. Even if work, relationships and social conditions were initially presented as isolated areas, my plan was to weave these into what they were: interrelationships in context. Two examples (Figures 6.1 and 6.2) will be given. The first is straight forward in that the respondent, Wendy, identified which areas were negative and which one was positive. A second example illustrates a respondent, Patricia, saying that some areas could be said to have both alleviating and contributing effects.

Figure 6.1: Typology of impaired social functioning

Wendy Moore, 38, married with 2 children. Born in New Zealand and resident in Australia for 2 years. Works part-time as a check-out assistant at K-Mart. Lives in a rented flat, which is in a poor state of repair and close to a noisy railway line.

WORK	RELATIONSHIPS	SOCIAL CONDITIONS
Alleviating (+)	Contributing (-)	Contributing (-)
Wendy finds her p/t, low status job rewarding and would like to get f/t work. 'My job's not much, I'm a check-out chick, but it gets me out and about and I like the people I work with.'	Wendy's relationship with her husband and son is 'poor'. She has considered separation but fears the consequences. She sees her son's demands as 'constant and draining.'	Wendy dislikes her physical surrounds and is concerned about 'the constant crises of money'. She said: 'This is a lousy place, basically a dump but what can we do? It is all we can afford'.

Figure 6.2: Second typology of impaired social functioning

Patricia Parker, 66, born in England. Arrived in Australia 6 years ago. Before that she had lived in Canada for 15 years and New Zealand for four. As a widow she receives a small pension and now lives alone in a one bedroom unit. She has a son aged 39 in Sydney and another son aged 41 in Canada.

WORK	RELATIONSHIPS	SOCIAL CONDITIONS
Contributing (-)	Contributing (-)	Contributing (-)
Since husband's death 2 years ago she has done little entertaining though she used to enjoy this activity.	Difficulty with 'anxious daughter-in-law'. 'She is not supportive. I can't give her any more'.	Being alone. Misses Canadian friends. Unable to capture Canadian lifestyle.
Alleviating (+)	Alleviating (+)	Alleviating (+)
Never unhappy being a 'housewife'. Can obtain help with domestic chores.	Good rapport with son and grandson. Good friends of own age, but relationships 'not deep'.	Owns own home. Financially can manage. Little anxiety over medical bills.

In terms of work in her home, Patricia did not feel unduly impaired. By contrast her comments about continued grief over the death of her husband and an unsupportive daughter-in-law did mean that overall she did not think she was functioning very well in terms of 'relationships'. Similar judgments were made about that area of her life categorized as 'social conditions'. She felt isolated. Her husband had died. In Australia she had not established that network of contacts which had meant so much to her in Canada. My conclusion about the balance of negatives and positives produced one positive (work) and two negatives (relationships and social conditions).

Only a few of the other 79 respondents were as difficult to classify as Patricia. Others could usually identify those areas of their lives in which they felt impaired. They almost always made an implicit and often an explicit statement about the impact of work, relationships and social conditions and in this respect the pattern for the total 80 respondents could be classified (Figure 6.3). This provides an overall picture of depression in terms of impaired social functioning.

Classification of Social Functioning

A first scheme of analysis grouped the 80 cases according to seven discrete patterns of alleviating and contributing features in the three different areas. An eighth pattern, which would have included three +++ did not emerge. These seven patterns show the different combinations of positive and negative, ranging from cases where people experienced work positively but relationships and social conditions negatively, to cases where all three conditions were labelled negative, i.e. were experienced as contributing to depression (Figure 6.3).

Figure 6.3 Patterns of impaired social functioning

WORK	RELATIONSHIPS	SOCIAL CONDITIONS	NUMBER
-	-	-	6
+	+	+	-
+	-	-	19
+	+	-	7
-	-	+	15
-	+	+	8
+	-	+	16
-	+	-	9
TOTAL			80

This figure shows groups of respondents with apparently common experiences. For example, we could first pick out the groups who combined two positive areas with one negative. Sixteen respondents experienced work and social conditions negatively but saw their relationships as positive. Seven respondents experienced their work and relationships positively but identified social conditions as negative. Eight respondents experienced their relationships and social conditions positively but identified their work experience as contributing to depression.

Alternatively, the respondents who identified two negative and one positive area of social functioning, a reference to the figures 19,15 and 9 above, could be isolated and their backgrounds discussed. However, this approach to analysis of the respondents' accounts and experiences would have involved going systematically down the columns. Such an approach might have had the

advantage of appearing systematic. It would also have been somewhat mechanical and less likely than other schemes to produce a picture of the social contexts of depression, in terms of the links between different negative experiences, or between negative and positive experiences.

A second means of organising the data would have been to separate the different conditions, (work, relationships and social environment) and discuss groups of cases where these areas were negative for respondents irrespective of their experiences in other areas (Figure 6.4). This scheme produced three patterns, (i) where experience of relationships was always negative, 56 cases. (ii) where experience of work was always negative, 38 cases. (iii) where experiences of social conditions was always negative, 41 cases.

Figure 6.4: Negative Patterns of Work, Relationships and Social Conditions

Work conditions negative irrespective of other areas:

Patterns			Numbers	
-	-	+	15	(14F 1M)
-	+	-	9	(4F 5M)
-	+	+	8	(4F 4M)
-	-	-	6	(3F 3M)
TOTAL			**38**	**(25F 13M)**

Relationships negative irrespective of other areas:

-	-	+	15	(10F 5M)
+	-	+	16	(10F 6M)
+	-	-	19	(13F 6M)
-	-	-	6	(3F 3M)
TOTAL			**56**	**(36F 20M)**

Figure 6.4: Negative Patterns of Work, Relationships and Social Conditions continued

Social conditions negative irrespective of other areas:

+	-	-	19	(13F 6M)
+	+	-	7	(7F 0M)
-	+	-	9	(4F 5M)
-	-	-	6	(3F 3M)
TOTAL			**41**	**(27F 14M)**

Figure 6.4 does have the apparent attraction of focussing on the different groups of respondents, 38, 56 and 41 who identified work, relationships and social conditions negatively. From their accounts, the connotation of negative experiences in these areas could be identified. But that connotation should emerge from accounts of the association of positive with negative experiences. For that reason a third way of portraying and analysing the data was chosen (Figure 6.5). This shows six cases in which respondents reported negative experiences in all three areas, 43 cases in which two negatives and one positive were reported and 31 cases which portrayed a one negative, two positive pattern. These three patterns of experiences have been labelled respectively, 'No relief in sight' (6 cases), 'Highly vulnerable' (43 cases) and 'Not so vulnerable' (31 cases) and as such they foreshadow the content of subsequent chapters.

Figure 6.5: Common patterns of interaction

Case Types	**Work/Relationships/Social Conditions**	
A: No relief in sight	Entirely negative experiences	6
B: Highly vulnerable	Two negative, one positive experience	43
C: Not so vulnerable	One negative, two positive experiences	31

Before proceeding to describe the experiences of these three groups, a final list of figures will be used to show how the three patterns were arrived at (Figure 6.6) . For example, in the group labelled 'highly vulnerable', 24 respondents experienced work negatively but 19 identified this as an 'alleviating' area in their lives. Of the same 43 people, 34 identified relationships as negative but only nine were judged as having positive experiences in this area. With regard to social conditions, this was a negative area for 28 respondents but positive for 15. This

breakdown of figures and some statement of the gender and marital status of respondents in the different patterns will be presented at the beginning of each of the subsequent three chapters.

Figure 6.6: Contributing & Alleviating Areas

	Work		Relationships		Social Conditions		Totals
	-	+	-	+	-	+	
No of cases 'A'							
- - -	6	0	6	0	6	0	6
No of cases 'B'	0	19	19	0	19	0	
- - +	15	0	15	0	0	15	
	9	0	0	9	9	0	43
No of cases 'C'	0	16	16	0	0	16	
- + +	0	7	0	7	7	0	
	8	0	0	8	0	8	31
TOTALS OF POSITIVES AND NEGATIVES	38	42	56	24	41	39	80

A final point worth highlighting from the picture emerging from Figure 6.6 concerns the areas of social functioning which appeared to have the most contributing and most alleviating effects in relation to the experience of depression. For example, in 56 (70% of cases, 'relationships' were identified as negative but work experiences were negative in only 38 (47%) of cases. Work experiences were positive in 42 (53%) of cases but relationships were only judged positive in 24 (30%). Experience of social conditions was distributed almost evenly between the positives and negatives.

CHAPTER 7

NO RELIEF IN SIGHT

The case types (Figure 6.5), from 'no relief in sight', to 'highly vulnerable' to 'not so vulnerable' depict accounts of role performance with reference to work, relationships and social conditions. A description of that role performance, through the accounts of the respondents, takes us a further step towards unravelling the meaning of the social context of depression. With that goal in mind, the six respondents who seemed to feel 'no relief in sight' will now be discussed.

Previous discussion showed the notion 'impaired social functioning' as a state of affairs described by the respondents as both social and psychological, financial and physical. Over and above comments about their health, which was often synonymous with comments about the nature of their depression, the sense of social impairment was an account of their inability to operate very well, in one or a combination of three areas of their lives: the world of work or, paradoxically, the experience of unemployment or retirement; personal relationships; and living conditions or social environment.

This typology (Figure 6.1 in Chapter 6) is intended to produce a picture of the social context of depression and the meaning of this condition in the eyes of the respondents.

Only six of the eighty respondents, three men and three women fell into this 'no relief in sight' category. The three men were all migrants to Australia, two from the Ukraine and one from Cambodia. The three women were all Australian born.

The ages of this group ranged from 38 (one of the women) to 58 (the male Cambodian refugee). In terms of marital status, only one of the six was married (a female), two were single and had never married (two males), two were separated (two females) and one was a widower.

The links between experiences at work, in personal relationships and with reference to social conditions will be described by justifying the caption 'no relief in sight'. Before we come to that description, the respondents' accounts of negative experiences in different areas will be documented, beginning with the world of work.

Conditions of work

With the exception of one 42 year old man who was unemployed, the common negative feature of work for this group concerned its unrewarding nature. One woman of 38 who was a process worker in a factory spoke of her boredom, which was compounded by the fact that there was no time or space for camaraderie with other employees. The sense of group solidarity in the face of a common predicament was entirely absent in the experience of May who explained her factory work, 'We don't get to talk much, the atmosphere is tense, the conveyer belt is not going to stop and do you a favour'. This sentiment was echoed by the other two women, one of whom was part-time employed in an office and the other in a full-time capacity. For Kaylene, her part-time job was pursued out of necessity, but she said, 'I drag my feet in there three times a week, but it's hellish. I try to keep out of the politics - but it's difficult. Sometimes you can cut the air with a knife things are so tense'. On the other hand, for the full-time clerical worker, Terry, the unrewarding nature of work was related to the 'hectic pace' at which she was required to work. Most of her work involved counter work where she had constant contact with the public. This work was alternated with the processing of health insurance claims, where she had to work to a strict deadline. She said, 'Sometimes I think I'll go spare - things get pretty hectic and the public don't appreciate the pressure we work under. There's hardly any time for pleasantries with your colleagues, that's what I miss - I had that at my previous place of work. But I have to work and at the moment this is my job and I have to put up with it'.

The unrewarding nature of work was also explained by two of the migrant men who explained that they were constantly reminded that their unskilled jobs were demeaning because they had much higher status and far more rewarding working conditions in the countries and culture they had left behind. For example, Sovyn from Cambodia had been a high ranking official in the government of Cambodia before it had been overrun by Pol Pot. As a factory worker in inner city Sydney no use was being made of his previous education and experience. On the contrary, 'I am a proud man, now I am 'unskilled' and it always reminds me of my previous responsibility'.

In addition to the inherently unrewarding nature of these people's jobs, the atmosphere of the place of employment made matters worse. This was an observation made already by the three female respondents. They had referred to the lack of opportunity to talk and to establish friendships with co-workers and about the strained nature of office politics. For the migrant men, this issue of atmosphere at work was a sharper issue. They experienced a distinct lack of friendship which often felt like discrimination. The Cambodian man said that people ignored him in his present job whereas in a previous job in Sydney, in a furniture factory, 'people talked to you there and did try to be friendly'. The experiences of a Russian migrant from the Ukraine were worse than a lack of friendliness. Izzy explained, 'I'm a Jew and I try not to let people know that at work. But they can't help teasing me about my English accent. I'm at my lowest when I'm being screwed by Turkish people. When you're a Russian being screwed by a Turk you know you are in a bad way.'

None of the four who had full-time employment were well-paid, and the low wages coupled to work which was unrewarding in other ways were a constant reminder of a Catch 22 situation. They had to work but the low pay was barely sufficient to pay for rent and food. The tedious nature of their jobs acted as a reminder that, temporarily at least, they were people of little consequence. Yet they felt they had no choice. One woman explained, 'I'm trained for nothing so it's a way of paying the bills'. Another woman said that she resented her job as it 'takes me away from my son. I'm separated from my husband and now I'm separated from my son. I'm working for him yet I'd rather spend more time with

him. But it's hard to knock back over-time especially when we need the money so much.'

The lack of choice over work and the prospect of never having a choice was also the predicament of the one unemployed person among this group of six. This man, in his middle forties, had been a skilled machinist, a fitter and turner. He had lost an eye in a car accident and had suffered complications following a recent hernia operation. Since those events he had been unsuccessful in obtaining employment and he felt that the government employment service, the CES, probably thought he was now unemployable. This made him, 'Occasionally bitter. I am bitter about who is ever going to give me a job. The CES has told me that after the age of 40 'there is not much chance'. So you are on some kind of scrap heap. With my one eye you can't read many instruments. I look unusual. Nobody wants me'. This man, concluded 'I face twenty years of unemployment. The best I can think of is that I won't live that long'.

The unrewarding nature of employment let alone the prospect of never again having satisfying employment of any kind, might have been alleviated by more satisfying experiences in other areas of their lives. Yet the sense of having no relief in sight was for this group not only a feature of the world of work (or unemployment). Difficulties in one area were compounded by dissatisfaction which often amounted to powerlessness in other features of their lives. Evidence of such negative experience and their effects was vivid with regard to these people's comments on their personal relationships.

Personal relationships

The way in which a lack of satisfying experiences in personal relationships contributed to depression was twofold. There were respondents who now had no intimate, supportive relationships of any kind. There were those who continued in relationships, in particular in marriage, but their expectations of pleasure from such relationships were not realised. The one group seemed to be almost totally isolated and the other were constantly disappointed.

The sense of isolation from others was a product of broken marriages and the feeling of being stranded as a migrant. Terry who was separated said that she no longer coped because; 'although I knew my husband was a drinker and a gambler, at least I had him to confide in.' She went on to explain that her relief from the feeling of being alone was in food, but overeating and being overweight made her feel she was less attractive to others, 'yet food consoles me. I eat then I feel guilty'. It was not just the broken marriage which contributed to isolation. Her mother had died some years ago. Her father with whom she had never been close was in a retirement village. An only brother with whom in any case she had nothing in common, lived 800 kms away in Melbourne.

Migrants' feelings of social isolation were sharp and painful. The lack of satisfying personal relationships was debilitating not only because of the absence of family. Even if a decision to migrate had not been forced on them, there was a sense in which the recall of a familiar community made the current lack of supportive relationships even more unbearable. Izzy said that in his old home in the Ukraine, 'At least I could have women, even though it was a highly moral place'. He explained that as he had grown older he had declined in physical appearance and his chances of obtaining female company had also diminished. Isolated from family or any reassuring sense of community, the companionship of women had become very important. He explained, 'There's no substitute for sex, but I just can't get it'.

A craving for intimate relationships was expressed by women and men who now felt isolated. In the case of some of the male respondents, it was the lack of a female friend with whom they could have regular sexual intercourse which was the most graphic reminder of their isolation. Levi, a Russian migrant explained, 'To have a regular girl-friend was also to talk to someone and to have someone to listen to. I could have five girl-friends at a time and feel somebody. Now with my injuries I've turned to drink'. He elaborated that you could not talk to alcohol, you could not have an intimate relationship with drink. Here was another Catch 22. In his sense of isolation he had turned to drinking but this had made him even less attractive to women. Isolated Terry in a neighbouring suburb had turned to food. Levi explained that too much drink had even made him lose interest in women whom he felt he needed. Drink gave some confidence but when he was

sober, 'I know I have not got a woman and I am less of a man. I think that is probably the worst thing to think you have lost interest in women when at one stage you might have had five or six. But who wants a drunken Russian with one eye?'

In discussing the predicament of some migrants even in a country which provides some support services, it is always important to consider the element of choice in leaving a country. In this respect, the distinction between refugees and migrants is significant. Sovyn was more of a refugee from Pol Pot than a migrant to Australia. He had come because one surviving daughter had persuaded him to do so, but, 'I mostly dream of going back'. He had lost his wife and four of his children when he had been forced to work in forests and fields following the Khmer Rouge takeover. In Sydney, 'days and days go by when I speak to no-one'.

Sovyn's isolation was also a product of status and class. There were other Cambodians living in Sydney but he saw them as mostly unskilled people with whom he would not have socialised in the days of Prince Sihanouk's rule and certainly not in the time of French colonialism. He had little in common with other Cambodians. He was a survivor from an educated elite. Without any supportive relationships he was now living in a shabby boarding house and working in a poorly paid unskilled job. Yet he also wanted the reliable company of a woman, 'to care for me, when I am sick. I can manage when I am fit, but being alone is so unpleasant when you are sick.'

In contrast to the isolated Sovyn, the respondents who were still in marital relationships potentially had someone they might turn to. But the failure of husbands or wives to listen to their partners, in the perception of these respondents, left a feeling of being permanently disappointed. May said that although she was still married, and in her view that was the best way of taking care of her three children, the lack of any satisfaction in the marriage contributed to her depression. She did not refer explicitly to an absence of love but instead described 'no-one to confide in' and 'no abuse but nothing warm'. She elaborated that sitting down in silence because they had rented a video for an evening was not evidence of a relationship. Life had not always been that way but with the arrival and expense of children and no relief from employment or leisure, she had

grown to expect little. Physically she was not as isolated as the migrant men described above, but in common with the other women in unsatisfying marital relationships, she had grown to expect little. She was fatalistic, as though nothing could ever improve. To expect little was to guard against the feeling of being permanently disappointed. Even the immediate social environment offered little relief.

Social conditions

The way in which social conditions contributed to depression instead of alleviating it was explained by these six respondents with reference to two different sets of factors. On the one hand, there were the material aspects of home and environment. On the other there was a sense of being trapped in an alien culture or in unpleasant surroundings. The 'material aspects' were usually described with reference to income and housing. 'Being trapped' was manifest not only in having no leisure but also in being culturally ill-at-ease, even lost.

At a time of increasing inflation, extremely high prices for accommodation and hardly any cheap property available for rent, all these respondents existed on low incomes. Only one of the six respondents lived in a home which she and her husband were paying for through a mortgage. But mortgage repayments absorbed over 40% of their combined incomes. The respondents paying rent were not spending as much on accommodation but rent for modest accommodation was a constant reminder that this was not their home. Terry had separated from her husband and this had involved her leaving the marital home for a one-bedroom flat which she shared with her ten year old son. She talked of the depressing nature of 'these four walls' which not only gave her a sense of being hemmed in but showed that in her case the cherished 'Australian dream of everyone owning their own home' would not be realised. She said, 'I know we will never have our own home, though it's been my dream'.

The pressures of living on or around the poverty line in which the struggle to make ends meet was a preoccupation was also a tangible feature of social surroundings. Constant shortage of money was evidence of lack of control. May explained, 'Things are real tough. It costs a lot of money to run three kids. If it's

not a school outing, it's school uniforms or shoes or a camp and even a sports day costs money.' In common with other mothers who found the costs of 'free' public schooling something they could not pay for, this mother said that the only way to afford things was not to afford them. 'The kids don't go on outings. They have to stay at home. I mean we can't be paying out all the time'.

Parents could economise by not sending their children on costly school activities, they could also avoid having any leisure activities themselves. Hiring videos was a cheap substitute for going to the pictures but another walk to familiar shops could never substitute for the lack of a holiday. A common feature of these respondents' comments about the negative features of their social surroundings was that there was little escape for them. They had not been away on a holiday for years and they no longer expected to be able to take one. If having a holiday is a means of preventing depression or alleviating its worst effects, this was a remedy which was not available to this group. Except in the case of the Cambodian who thought he might one day return to his homeland, they did not consider a holiday to be a remote possibility.

The sense of being trapped by their social surroundings has been illustrated already by mothers who spoke of preventing their children from participating in school activities and by the disappointed, and sometimes incredulous answers 'no' to the question 'have you had a holiday within the past year?' The sense of being trapped in an alien culture was expressed by the migrant men. Izzy, the Ukrainian explained that although the streets of his Sydney suburb were crowded, they were like a desert. In common with another Russian migrant whom he knew, he said that the best he could do was to wander around 'looking for other lost people'.

The notion of 'lost people' was explained with illustrations of three things. In the first place, migrants saw themselves as part of a group of people who had been obliged to move from one country to another, always seeking refuge, always trying to escape persecution. For example, Levi's family had escaped from Bolshevik Russia to Manchuria where they had become public servants with some security and status. With the advent, in the sixties, of the cultural revolution in China, they had become migrants again, this time ending up in Australia. Soon

after arrival in that country, his parents had died and he sought solace and company with a handful of other migrants of similar background.

The second feature of being lost concerned the lack of confidence in speaking English. Levi felt shy about his inability to speak English fluently and usually tried to hide his powerlessness until he found others who were also trying to conceal the same problem.

The third characteristic of the 'lost people' concerned not so much their traits but rather the values of the dominant culture. This was expressed partly with reference to an absence of community feeling and partly by criticism of Australians' insensitivity to the values of other groups. Crowded streets where people seldom spoke produced loneliness, 'I don't like a place which is free but where you don't even speak to your neighbours, or if you do they don't speak to you. This was the feeling of Levi who lived in a Housing Commission apartment block which was home for 40 others, none of whom he knew.

Insensitivity of a dominant culture to the values and life styles of new Australians was evident not so much in terms of outright rejection or discrimination but rather by indifference or attitudes of well meaning clumsiness. When Sovyn had moved to his current boarding house, the members of a Christian church had tried to befriend him. He explained, 'They tried to be helpful, to get me to join. I was supposed to learn about Jesus Christ. I tried to learn about Jesus Christ. I have real problems. I do not like a religion that emphasises the importance of 'being good' and therefore 'being bad'. I am a Buddhist. All my family were Buddhists. Buddhism means a community of friendship. I don't have any community here'.

No relief in sight

In terms of assessing what depression meant to people and which aspects of their lives could be improved if the depression was to be alleviated, the point to be made about this group concerns the links between experiences of work, personal relationships and social conditions. The social context of depression was the

product of all these experiences, each acting upon or compounding the other. Work provided no refuge from the unsatisfactory experience of relationships. Social surroundings gave individuals a sense of being trapped. That being trapped feeling is often described as a clinical characteristic of depressive illness. The same characteristic was identified by each of the six respondents in this group as a social phenomenon. In no sphere of their current lives did they experience people or events which alleviated their sense of being weighed down.

The notion 'no relief in sight' has been coined to characterise the state of impaired social functioning in this group. The words 'no relief' mean no contours, nothing different, a plain predicability. This became apparent when the respondents were interviewed about their experiences of crises and their accounts of highs and lows in their current lives. The word crisis and the adjectives high and low did not give an apt description of their feelings or their circumstances. The crises in their lives, broken marriages, death of a parent, migration to another part of the world, a disabling accident or illness, had already occurred. They had adjusted to those or at least they thought they had. But the adjustment meant living on a plateau where nothing happened and nothing seemed likely to happen. They could barely retain any orientation to the future because they had lost hope and lived from day to day. The trouble with this plateau was that it seemed to be going down hill.

Questions about highs and lows in people's lives are based on an assumption that good times may compensate for bad ones. Yet for this group, the experience of depression meant that such questions were met with a wry incredulity. Sovyn said that the low times were every day of the week. 'If high means feeling better, it is when you are not sick'. For Terry, the best high time she could imagine was 'not having a repeat of the last twelve months'.

Despite the sense of a plateau with no relief in sight, these respondents hung on to a hope of survival and wanted to be seen to be strong. They were not without hope, of finding a mate, of having a holiday, obtaining a better job, winning a lottery or returning to a homeland. But if treatment for the recent plateau of experience was to be realistic, it would have to build on this slight hope and do so one step at a time. The experience of work, relationships and social

conditions would have to be addressed in combination. The consciousness of these respondents had become a mirror of the context of their lives. Their depression was as much a social and political statement as a clinical condition. That theme will be pursued when I discuss the notion of non-medical alternatives to treatment.

CHAPTER 8

HIGHLY VULNERABLE

This group of 43 respondents, called 'highly vulnerable', had identified two areas of negative experience and only one positive experience: two areas of their lives produced conditions which they said had contributed to their depression. There was one area which they said alleviated their depression. Within the overall paradigm, these 43 respondents were 'in the middle', there was some relief in sight for them, but they were more vulnerable than the group who identified one condition as contributing to their depression.

Of these 43, 19 fell into the category where work was experienced as positive, but relationships and their social environment were perceived as negative. Fifteen respondents said their experiences were of negative work conditions and relationships, but positive social conditions. Nine respondents experienced the combination of negative work experiences, positive relationships and negative social conditions. With reference to these different patterns of negative and positive experiences, the gender and marital status of the respective respondents was identified (Table 8.1). However, as this figure shows, nothing could be inferred from such a pattern.

Table 8.1: Highly Vulnerable Respondents

	Gender		Marital Status			
	M	F	Married	Divorced or Separated	Single	Widow
Positive exp. of work) Negative exp. of relationships) Negative exp. social conditions)	6	13	6	5	6	2
Negative exp. of work) Negative exp. of relationships) Positive exp. soc. conditions)	1	14	9	2	4	-
Negative exp. of work) Positive exp. of relationships) Negative exp. soc. conditions)	4	5	6	1	-	4
TOTAL	11	32	21	8	10	4

Taking the pattern established in the previous chapter, each of the separate categories will be examined in terms of the issues which emerged for the respondents. However, this group of respondents have two areas in which they experienced contributing features to their depression. In that respect they differ from the previous group and the group which succeeds them. For the former group, because all three areas were experienced negatively, the analysis concentrated on the issue which emerged for the respondents in each of the three separate areas of work, relationships and social conditions. At no point was it suggested that these areas were discrete or watertight. Nevertheless, the meaning of negative experiences in those three areas could be examined.

For the purpose of tracing the experiences of these respondents, I shall examine the pairings of those areas of their lives which contributed to their depression. This scheme produces three groupings A, B and C. The first of these refers to those respondents who said that their experience of relationships and social conditions was negative.

(A) Negative Experiences in Relationships and Social Conditions

Despite differences in types of relationships, conditions and material resources, these respondents perceived relationships and social conditions negatively. Two different themes explain their experiences in relationships: there were those who were in unsatisfactory and unsatisfying relationships; there were those who had no significant relationship and regarded that as impairing. Included in this group was a single woman of 28, whose damaging past experiences in relationships left her feeling 'relationships are bad and I don't need one. The problem is other people sitting in judgement of me, you know, thinking I need a relationship, so in that sense, it's a problem'.

Negative Experiences in Relationships

(i) Unsatisfactory and unsatisfying relationships

Some respondents were reluctantly playing the roles of partner and often parent. Such relationships hindered their coping abilities, but for reasons of

convenience, they persisted with such living arrangements. These were all women. They felt trapped in relationships which were contributing towards their inability to cope in other areas of their lives. Of five women who spoke about their entrapment in an unhappy relationship, three had already experienced at least one previous separation from their partners. They had considered seriously the issue of permanent separation. Their descriptions of being 'trapped' and 'caught', conveyed bitterness, struggle, resentment and anger, and very little hope.

Several women made connections between their individual plight and that of other women friends and acquaintances. They understood the social and political pressures involved in maintaining an outward appearance of a seemingly happy family life. For example, Lisa, a 40 year old professional woman who worked part-time as a pharmacist and was married to a successful barrister spoke of internal as well as external pressures to 'keep appearances up'. She said:

> My relationship with my mother has always been bad, I find her overbearing and dominating....sometimes I think I married Les to get away from her... But that's been just as much of a disaster. We've separated once, gone into counselling and, if I'm honest I'd have to say we got back together for the kids' sake. We have so many problems, we don't communicate and there are sexual problems as well, but here we are together! And why? Because of the pressure to play happy families - pressure from my family, his family, society - not to mention my own guilt...; the same thing's happened to two of my friends....we're all living unhappily ever after!

A similar account of lack of satisfaction, separation and eventual return to a bad relationship was given by Wendy, aged 38. She described herself as a 'part-time check-out chick', while her husband was a 'jack-of-all-trades'. In her words:

> Our relationship isn't the best - it's always been up and down. David's so possessive....he more or less blackmailed me to come back to him this time - using the kids as bait. He really put the guilt trip on me, he even let my parents know, he rang New Zealand just to tell them I'd left....my parents were onto me to 'go back to my family'. I felt like I was being pressured on every side - and I gave in but, its not working.

These two women were aware that they were not alone. They were unhappy but felt obliged to accept their predicament. They felt they had no

choice. This sense of having no choice was evident in the experience of other women. For example, two women reported living in relationships in which they said they received neither respect nor love from their partners. One of them said, 'we barely talk to one another'.

A woman who did talk with her partner, nevertheless explained that she and her partner felt obliged to be 'part of a couple'. Fay, aged 41, a part-time clerical worker was married to a motor mechanic. They were childless, so the issue was not the children holding them together but the expectation to be 'part of a couple'. Fay spoke of an excess of communication not an absence of it:

> It's a long story so I'll give you the short version. My husband and I have this real love-hate relationship - real stormy. We've separated and got back together twice. Now - it's like we're fatally attracted....some of it has got to do with being part of a couple - I don't know anyone my age still alone - we've talked and talked about this together until we've gone around in small circles. Why do we persist? Maybe because we're expected to - everywhere you look you see couples or families, not many people by themselves, wandering around.

Another four women found their relationships unsatisfactory and unsatisfying because they felt drained by them. Two women experienced their relationships as draining because of their husband's sudden onset of illness and the need to adopt a nursing role. Both of these women were in their early fifties. They found themselves in a difficult and demanding role for which they had not been prepared. Maggie, 54, said, 'My husband's heart attack took me by storm....he's pretty much an invalid at the moment and I'm worn ragged looking after him - it's drained all my energy'.

Caring for a sick person was demanding physically, socially and financially. Although their relationships with their husbands were in some respects satisfactory, they experienced their living arrangements as contributing to a sense of impairment. Both women hoped that their husbands would recover and their relationships would regain some 'balance'. This balance, a reference to feelings of mutuality in roles and responsibilities, was described by the other women in different ways. Gillian, 34 years old and recently separated, spoke about the pressures involved in leaving her husband and his refusal to accept her decision:

> Life is one big hassle right now. I've left my husband, but you wouldn't know it - he comes around every night, he threatens me and we fight like mad. He wants me to go back but what for? He drinks and abuses me and the kids. I'm frightened and I don't want to go back. I don't like him coming around and hassling me either.

The emotional stamina involved in the scenario described by Gillian drained her physically and emotionally. It had an ill effect on her health: she said that her depression reflected this pressure not least because 'social conditions' compounded the difficulty she experienced in relationships. (This is a point to be elaborated later in this chapter). Other respondents said that their recall of previous experiences in relationships as having been draining, now deterred them from any serious contemplation of a new partnership. Lucy, a 44 year old widowed migrant recounted how she had struggled with depression after her husband committed suicide two years after their arrival in Australia. She explained she had one relationship five years later, but that had been a 'discouraging experience'. In consequence, Lucy said she now had 'no energy left' to sustain a relationship:

> Sometimes I feel lonely, but its better not to be involved now... After my husband died I was very lonely, only new to this country....two years ago I started a relationship with a younger man, also South American, but he wanted too much from me....I also got pregnant and I had an abortion....he was angry and we parted... Maybe I will feel better about a relationship later....I can't think of having one now....it would make me too tired.

Social and political pressures were keeping some people in bad relationships, while others had found previous relationships so draining that they were ambivalent about ever embarking on a serious association with a partner again. Ironically, similar pressures were being brought to bear on those 'deviants' who were not in relationships and who reported their need to have an ongoing, significant relationship. On the other hand, there was one respondent, a 28 year old woman for whom the thought of a relationship was too painful and who said she wished to avoid a relationship at all costs.

(ii) 'No relationship and desperate for one' and 'Not looking for a relationship'

'No relationship and desperate for one' were words spoken by a 45 year old man, a self-employed painter and decorator. He had divorced six years previously and saw his 10 year old daughter every second week-end. Danny was typical of this group of six men and three women who wanted a relationship and felt their sense of impairment was, in part, a product of being alone. A common thread in all their narratives was that of their own and others' expectations to 'pair off'. Some of them had been involved in relationships, even long-term ones, in the past. Only two respondents, a 46 year old man and a 17 year old female said they never had any previous significant relationship.

Despite a sense of a previous hurt and disappointment, the need to be seen to be in a partnership came through strongly. Some of these respondents made links between their private emotional need to have a relationship and their perception of society's expectation that relationships were natural and good. John, a 40 year old partially sighted clerk who had experienced a bitter separation only nine months earlier explained:

> I would never have thought after my separation that I'd be thinking of getting into another relationship. There's still some hurt left and I've got some doubts about relationships, but the bottom line is I need one. It's not only that other people keep pressuring me and trying to line me up with dates, it comes from within. I'd feel better now if I had a relationship, it's not so much the sex but being able to talk, do things together, the companionship thing.

The issue of companionship was highlighted by a migrant Indian woman of 38, who taught English as a second language. On the question of relationships, Arna commented, 'it's difficult to say anything without going back to Adam and Eve':

> I want to share my interests with someone who has similar inclinations... But one doesn't want to pretend to be interested in bush walking or to go to the Opera with somebody who has no interest in such a topic...being matched is important, not just anyone will do.

Another woman who commented on striking a balance between the freedom of being alone and the rewards of having a companion was Jessica, 40, who had been divorced twice. She worked as a book-keeper. Her children were living independently. She lived alone in a small flat. She explained that she desperately wanted to be involved in a relationship with a man, but there were caveats. She said:

> At times I get desperately lonely and crave company and the warmth of a body next to me in bed, but then I think, stuff it! I can manage without a man - my track record is not good....I've vowed never to get involved with another dominating, manipulative man - I've suffered too much at their hands....I'd like a nice, sensitive man who understands my needs as well as I understand his.

Reference to the emotional need for a relationship was expressed in different ways. For example, two men referred to their need to be needed, to have the opportunity to do something for someone else. Guiseppie, aged 48, described his occasional 'desperation' to be involved in a relationship. He said that this was related to 'being able to help a wife with small things she couldn't do, to be able to say I was a good husband'. Jack, 66, said he had cherished his single status, but this was now a source of concern. He wanted to transform his independence to a state of interdependence, 'I'd like to know there was someone there for me and by the same token I could be available to someone - a person I could feel close to, someone I could depend on and they could depend on me'. He said that he had been lead to these views by his increasing sense of isolation since his retirement.

On the other hand, there was one respondent, a 28 year old nursing sister who felt driven to desperation point not because she craved a relationship which she didn't have, but because she perceived society's strictures as making demands on her which she had no intention of fulfilling. Jenny was adamant that relationships were unnecessary and her only regret was other people's attitudes. She said she was 'not looking for a relationship' but constantly felt 'society's rules being pressed onto me'. She expressed her anxiety, annoyance and frustration in not wanting to play by these rules:

> I've never had a male-female relationship in my life....the thought of being with a man turns me off. I blame my father for this - he abused me and my mother, for letting it happen - I might never have a relationship and what the hell - it's living in this society with its

> pressures to get married that's the problem. Sometimes I feel like a freak but after all, nuns are in the same position. Maybe I should give up nursing and become a nun!

Assumptions about human emotional needs and the importance of relationships, may be a taken for granted feature of dominant mores in Australian culture, but it is clear from some of these responses, that there is a tendency to look for a particular sort of relationship. Arna wanted a friendship with someone with whom she had a cultural affinity. Jenny felt ill at ease at the prospect of any such friendship and did not see the need for any alliance.

When respondents spoke of their negative experience of relationships, the exact meaning this held for them was more complex and intricate than might at first appear. As with the area of relationships, no assumptions should be made when respondents spoke of their perception of negative social conditions.

Negative experiences of social conditions

The notion of 'social conditions' is not an account merely of physical circumstances, but includes broad social and political trends. It also encompasses explanations about people's expectations of themselves, their life-styles and identity, as illustrated by cultural and psychological criteria. Consequently, social conditions refer not only to tangible and material factors but also to intangible, subtle aspects of respondents' lives. Among these 19 respondents, three issues emerged. The first concerned accommodation, with some respondents expressing distress about the high cost of rents and mortgages while others spoke of their home being either too cramped, or alternatively, too big to maintain. Secondly, the issue of being confronted by changing community standards and values was raised as a difficulty. Thirdly, a number of migrants spoke about the issue of culture shock and the need to constantly struggle with cultural differences and yet retain a sense of identity and thus a feeling for their heritage.

(i) Housing hassles: financial and emotional concerns

Fourteen of the 19 respondents (five males and nine females) expressed concerns about their housing. Some complained about the stress caused by high rents and mortgages. In four cases, the respondents reported that almost half of their household income went on rent or mortgage repayments. High rents seldom meant superior accommodation. Housing standards were poor. Landlords and real estate agents were reported as reluctant to do the necessary repairs. Wendy, who lived in a cramped flat next to Sydney's busiest railway line complained:

> I hate where we live, it's old, noisy and grotty, I find it depressing - but we've got no choice....I can't believe the prices in this country, back in New Zealand, we'd be living in a palace for this rent... Not only that, the agent, reckons the landlord is mean - we've asked to have a hot plate and a power point fixed for months now, but nothing doing.

In the same vein, Gillian was angry about high rents and her powerlessness to do anything about such an issue. She said:

> This is nothing more than a shoe-box, but its all I can afford... Before we moved in, the agent promised that the walls would be patched and painted, but now when I ring him, he ducks for cover. I'm pissed off with him, but I don't want to make waves in case the rent's put up.

This sense of powerlessness and fear to complain was echoed by David, a 46 year old single man who had lived in the same boarding house for five years. His rent had recently increased by one-third. He said:

> I don't like to complain because I get a good deal really, but when the board went up so much I got a shock. Others complained, but it just caused a scene. Its best to accept it if you want to stay.

There was a simultaneous acceptance and distress expressed by these respondents who saw such conditions as affecting their mental health. To put it more explicitly, such social conditions debilitated them. They eroded the quality of their lives. Others expressed this feeling for different reasons. Keith, a 43 year old single man who worked as a storeman and had recently lost his mother, hitherto his only companion, said:

> I really miss Mum....somehow the place seems too large now - just me rattling around in it with all the reminders of Mum....I've thought of selling but its too much effort right now.

The problem of 'too much space', and painful memories of sharing that space with a loved one was expressed by two other men. Since his wife and children had left him, John, had lived alone in a three bedroom house. He explained, 'furniture itself is a constant reminder of my family. I've even thought of selling it all and refurnishing'. The second man, Guiseppe shared his home with his two adolescent children, but the memories of his wife were overpowering and painful. He said:

> Everywhere I see her. She loved these Virgin Mary statues and the cross over the door was a present from me on her birthday... She died not long after that....I've left her bedside table as she had it - I want to keep it, but sometimes I look at it and cry.

For these respondents, there were tensions between the good and painful memories that their homes, furnishings and ornaments represented. Tensions and contradictions concerning individuals' aspirations and those of a wider society were also themes for other respondents.

(ii) Values, expectations and confrontations

Those who spoke of the mis-match between their values and expectations and those of a changing community felt impaired by the confrontations they experienced. Danny's observations epitomised the feelings of this group:

> I know I'm not poverty-stricken but you'd think I'd be better off....the taxes in this country are crippling... Once upon a time, if you worked hard you got some rewards some respect but now, people's standards have slipped.

This lack of fit between the respondents' ideology and what they perceived to be the current and dominant political values were expressed in a number of varied concerns. Jack spoke about his support for the current Labor Government and his distress regarding the powerful medical lobby and its attempt to dismantle Medicare. He felt that the current government should 'stand up to the opposition more, like they did in the past'. His concern centred around the increasing

weakness of government in the face of influential lobby groups. With a different issue in mind, Dawn, a self-employed hairdresser lamented:

> We have become far too governed in this country....bureaucrats and politicians are now on about interfering and over-governing us. That's the problem with Australia....in my earlier days I saw much more independence in people....there are far too many dependent people bludging off the State.

She had been investigated by the Tax Department, an experience, which she said confirmed her views that long hours and hard work were not rewarded but rather held in suspicion by bureaucrats. Two other women, both young mothers, spoke of their distress with what they perceived to be falling educational standards. In the words of Gillian:

> It's not like my day when we had a firm grounding in the three R's....Children are not disciplined....I don't mean the cane, but with words....they can get away with blue murder... It get me down because education is important... It also gets me down when I have to devote spare time to virtually coaching the kids - almost remedial work with them - its a disgrace... I hear private schools are better, but who can afford that?

These people contended that their values and expectations of life in Australia had been confronted by changing attitudes, by government policies and by the practices of government departments. They thought that these developments affected them detrimentally. The next group of respondents also experienced tensions between their expectations and the reality of their everyday existence.

(iii) Cultural clash and cultural retention

For the four migrants in this group (only one of whom came from an English-speaking country), there were constant tensions between the old (even if migration had taken place 25 years ago) and the new culture. These tensions ranged from adjustment to differences in physical environment and pace of life, to religious beliefs, social mores and cultural attitudes. For Wendy, the contrast between a small industrial town on the north island of New Zealand and inner-western urban Sydney was distressing, in that she felt a threat to her personal security:

> I hate it here, life's so fast, everyone's in such a rush and you always feel threatened, I hate travelling at night....back home people were friendly and had time for you....most of all, I felt real safe.

This perception of a lack of concern, amounting to indifference or even hostility from Australians towards outsiders was felt acutely by non-English-speaking migrants. They (one male and two females) had suffered some indignity or humiliation, in the early period soon after arrival in Australia. Lucy spoke of her inability to teach in Australia without virtual requalification, which she found impossible due to the demands of resettlement. Getting a job and saving were high priorities and she felt unable to meet the time-consuming process of having her overseas qualifications updated to Australian standards. She worked as a clerk but felt underemployed. Reluctantly she had settled for this but believed there was no prospect of her ever teaching in this country. Guiseppe said he could still hear his colleagues' taunts, 'wog' and 'dago' on the building site where he began work 25 years ago. Even today, he was still taunted by other workers (even though he is now their boss). For Arna, the trauma of almost being deported and the officious attitude of bureaucrats had been a particularly negative experience:

> If anyone can avoid depression under those circumstances please introduce them to me....I wanted to believe it was not a racist act....so many claims are made about how tolerant Australians are and I wanted to believe this but it was hard.

Although Arna appealed under the Freedom of Information Act to discover the official reasons for her being denied Australian citizenship, she recalled 'I bear the scars of that battle with Aussie officialdom'. (A decision to deport her was reversed on appeal and she had become a permanent resident in Australia).

On a number of issues, official policies and practices were perceived as unfair. These migrant respondents also experienced the unofficial and informal rules and mores as having a depressing effect. The secular nature of Australian society was and still is a shock to Guiseppe and Lucy, who came from countries with a strong Catholic heritage. They continued to practise their faith. They had to manage the tensions involved in living in what Guiseppe called a 'grabbing, money, money, money, Godless society'. Lucy said that her humanitarian values stemmed from her Catholic beliefs. She found the cult of individualism disturbing. She said:

> It's the way people always look out for me, me, me and my needs are greater than yours - I think is distasteful. It worries me....there are no strong values or mores in this culture - except 'anything goes' and 'she'll be right' which are both expressions of indifference. That is not a solid base to build on.

This indifference perceived by Lucy was also experienced by Arna. She felt confused by the way Australians tend to 'knock tall poppies'. She described her distress at this practice and her concern that visionary public figures were not respected:

> Australians don't respect people with vision and charisma. They like to de-value them. I'd had contact with Al-Grassby and he is rather charismatic and unique...but Australia has treated people like him and Elizabeth Reid in the most detestable way... You have such wonderful humane people and you've made a mockery of their humanity.

Migrants to Australia, even self-financing Anglo-Saxons, often reported that their welcome seemed ambivalent. They also recalled their own confusion, anxiety and often despair in the first few years after arrival. The migrant respondents in this sample were no different. None of them reported an easy passage to becoming Australian citizens. But some of the tensions and clashes they experienced and their determination to retain a fragment of their homeland had produced conditions which for a long time were experienced as very disabling. Lucy summed up her situation:

> I'm a naturalised Aussie now and after seven years, its much easier....I think I understand the mentality... But I will always dream of Chile, remain interested in what's happening there and yes, I want to cling to some old customs and ways....it will keep me sane.

'Keeping sane' in a society perceived as challenging their beliefs and values was not easy. It undermined their sense of identity and integrity.

These nineteen respondents shared their thoughts and feelings regarding what they saw as contributing to their feelings of impairment. For them, impairment in relationships flowed into negative experience of social conditions, and vice versa. Poor self-image generated from the experience of relationships made pessimism about other areas of life inevitable.

(B) Negative Experience of Work and Relationships

Many of the respondents in the former group spoke of work as a haven. But for another 15 respondents, work was not a haven, not a form of encouragement, never an oasis, but rather a major source of stress. Work problems ranged from dissatisfaction with conditions of work, one's position at work, frustrations over demotion, or no opportunities for promotion and a sense of being undervalued and feeling bored.

Only the social conditions experienced by this group alleviated their sense of impairment. With reference to their experience of work, a number of themes emerged. [1]First, there was a collection of respondents, comprising five females and one male who spoke of adverse working conditions. Secondly, another five respondents, all female, believed themselves to be undervalued and bored at work. Thirdly, there were four women who were unhappy with not doing 'real work' and said they wanted to 'work for money'.

Negative experience of work

(i) Adverse working conditions

For the six respondents who spoke about adverse working conditions, three women complained that their work was too demanding and the pressures on them to work to a deadline added to their sense of impairment. In addition to these pressures, there were authority issues for two of them and a 'personality clash' for another. Sue, a 36 year old single nursing sister who had moved into pharmaceutical sales, described her experiences at work:

> I enjoy the people, a lot of my customers are great....but the travelling gets me down and the routine and meeting deadlines means pressure and more pressure....I fell apart at the sides last week and I cried and cried....people were good and I took the rest of the day off, but I'm

[1]Again work was taken as meaning both paid or unpaid work. The work of four women consisted of 'home duties'. One was an aged pensioner, one woman was in receipt of Supporting Parent's benefits and 2 women aged 28 and 36 respectively were caring for children at home.

> frightened that if my immediate boss wants some ammunition, I've given it to him....he's the type who like to lord it over us.

For Sheree, a 26 year old credit clerk, there were similar issues: pressure to work to deadlines and an authoritarian supervisor. Her dilemma was heightened when she was told she was being 'too nice' to some customers from whom she was meant to be eliciting back payments. She said:

> I'm unhappy at work where I feel like a performing seal, my supervisor can see me and hear all my phone calls... He's a real bossy man and I can't seem to please him... It's like working in a pressure-cooker, and I've been told I'm too nice to the people who owe money and that I'll have to adopt a harder manner with them. I can't understand how you can get money from people if you behave like a bitch to them.

While the stress of meeting work requirements and pleasing one's supervisors was likely to add to these respondents' sense of impairment, so was the scene described by Beth, aged 37, a solicitor. She spoke of the sense of impairment which came from persistent competition and battles with a colleague at work:

> It's not as if the pressure isn't great enough, but added to that I have to put up with sparring from one of my colleagues....he and I have a war on our hands, a real personality clash, which gets me down at times.

These three respondents talked about their depression as being related to conditions at work: to their supervisor's expectations and to interpersonal difficulties. For another three respondents, their sense of impairment centred on what they perceived to be unsatisfactory working conditions.

Lee-Ann, 28, a nursing sister, was unhappy about her shiftwork. Although she had accepted this as a fact of life when embarking on a career in nursing, she now believed her two-year old relationship was suffering. She explained:

> Shift-work was O.K. before I was married....I think our relationship would be better if I didn't have to do shift-work - I resent shift-work and I know Ian does, but its a Catch 22, as a nurse. I've no choice....maybe I should get a nursing job where I can get permanent day work, trouble is, I enjoy hospital work, it's the damn system.

While the actual nature of the work Lee-Ann found to be satisfactory, her frustration with 'the system' was unambiguous. For two other respondents also, it was 'the system' which contributed to their predicament. Ellen, a 38 year old married woman, who worked as a full-time teacher said:

> I'm frustrated with my work - it's a terrible system ....because I'm a woman, I have precious little chance of promotion - I work in a Catholic Boys' school and it's all the Catholic boys, you know, the teachers, who get the promotions! It makes me so mad but I can't leave until I find another job.

Ellen was frustrated and angry about the obstacles she saw to her promotion. Ron, 28, a single man who had a junior executive position in a large multi-national company expressed his emotions regarding his demotion:

> Words can't describe how I felt....I was moved sideways into a research position, I know nothing about research....I went into the depths of depression.... My whole world came crashing down around me because the ladder I thought I was climbing was taken from under me. It was absolutely no use people trying to console me or telling me I was being irrational or silly. For me, not being able to go where I thought I was going, and been almost promised, was devastating.

These respondents who spoke of 'the system' thwarting them felt they had no prospects. For some people, these frustrations may have acted as merely everyday occurrences, and challenges to overcome. Not so for these respondents. They described the negative impact of working conditions on their ability to function effectively in other parts of their lives. Instead of being challenged by 'the system' and obstacles in their path, they were 'beaten down' by them and felt depressed. A sense of depression was also experienced by those respondents who spoke about being bored and feeling undervalued.

(ii) Undervalued and bored

Five women spoke of experiences of being bored and feeling undervalued, as though a cancer was eating away at their sense of identity and integrity. There were three secretaries, all working full-time and two teachers, who were part-time workers. For these women, there was little sense of achievement and a lot of frustration regarding work seen as repetitive and often demeaning. Added to this,

was their sense of 'not being valued' for what they did. Miriam, 42 year old and divorced, was annoyed by the attitude of some of her colleagues who did not give credit to the many and varied tasks a secretary was required to perform. She said:

> Some people treat me like I'm rubbish - give me orders and don't bother to thank me... They're pleasant when they want work done....but when it's done, they forget to say 'hello' to you the next day... Being a secretary can be demanding and often even challenging, but not many people recognise that.

Similarly, Robin, 28, recounted how 'everyone relies on me, but I get little official recognition'. In the small office in which she worked, she felt she was required to do more than just secretarial tasks, but received neither recognition nor reward. Robin worked in a voluntary agency. She was sometimes required to do more than her statement of duties demanded, as she explained:

> Sometimes I'd even do a bit of counselling of people who rang in if the others were busy....some of them were good about it....I don't mind doing that as long as I'm treated well....but even then there's a pecking order and I'm made to feel like I'm well and truly at the bottom.

In common with these secretaries' complaints, were those of the two part-time primary school teachers. Neither woman could work full-time because of family commitments. Both spoke of the creative energy required to teach small children, and ironically, the monotony of some of it. Neither experienced positive feedback from either the school administration or the parents of the children they taught. One said that often parents would complain about some aspects or other of the teaching or curriculum. Margaret, 43, married with two children said:

> Teaching can be such a thankless task....not that I'm expecting any prizes, but it's hard to continue without good, reinforcing feedback....it's even more demoralising when you get unwarranted and ignorant gripes from parents at meetings.

Elaine, 36, married with a pre-school aged son commented:

> I put so much energy and effort into my teaching, but it can be frustrating and a little tedious sometimes, and that's when I double my efforts....but there's precious little feedback....except that the students often show such progress that that's appreciation enough sometimes... It would be nice to have more formal support....but maybe it's because I work part-time....probably not though.

These women's experiences of work left them feeling frustrated, low and depressed. Even occasional feelings of optimism were whittled away by their perceptions of the 'tedious' nature of work, by being 'treated like rubbish' by colleagues and by feeling 'demoralised' by unwarranted criticisms.

While these women were disgruntled with their employment, four other women believed that their sense of impairment was related to not having the opportunity to work in the outside workforce.

(iii) Wanting to work for money

These four female respondents felt a sense of grievance which stemmed from their belief that they were deprived of the prize of work. They had idealised perceptions of working life. To Meg, 63, work meant 'being in the thick of things'. It was what work represented to her that was important, although she admitted she would not 'knock back any extra money':

> I'd rather be working....not tucked away here in this small flat where no-one knows if I'm dead or alive.... I hated having to retire to soap-operas and talk-back shows... I'd have kept on working but they wouldn't let me....the money would be better than the pension too.

The three other women, though younger, also said that work represented what they believed to be missing from their lives. They could have a place to go and colleagues who would be supportive, plus a wage and a feeling of belonging to an organisation. Their attitude to not working in the labour force also spoke volumes about the meaning of 'staying at home'. Kim, 28, married with two small children said:

> I gave up work, reluctantly mind you, after my first child... I miss working....getting dressed and going out, meeting people, being busy, feeling useful all day....being a housewife - don't you just hate that awful word? - is boring. You do the same things da in and day out and all you've got for company are Humphrey B. Bear and stupid soapies... Sometimes I think I'm going to go spare!

The stimulation provided by moving outside the home and interacting with others, as much as the salary by which paid work is rewarded, was also the issue for Sharon. She was a 38 year old divorced woman with three children, living in a Housing Commission home and in receipt of a pension. For Sharon, finding employment was an attractive proposition, yet there was also a big disincentive to do so. This ambivalence related to her pensioner status and Housing Commission accommodation policy:

> I'd love to work full-time, but it's impossible - my rent would be put up so high....it means I'm caught, if I want a low rent, I have to stay on the pension... I could work now and then, or part-time, but everyone want to do that and there aren't enough jobs to go around... I know this sounds crazy, but I think working is glamorous, you can get dressed up and leave the house and as the song goes, leave all your woes behind... Instead I'm trapped here all day with them, bored out of my mind.

In summary, adverse working conditions and a sense of being of little consequence in the workplace made for negative experiences for some respondents. They felt hampered by the stresses of work commitments, rude colleagues and official indifference. For others it was the absence of paid work which made them feel depressed. They experienced a sense of aimlessness, and a desire to belong to an organisation. In addition to these negative experiences of work, the relationships of this group were also identified as contributing to their depression, as though the one compounded the other.

Negative experiences of relationships

(i) Unsatisfactory and unsatisfying relationships

As with other respondents, there were people who were dissatisfied with a relationship in which they felt trapped. There were seven women, all married or living in long-term de facto relationships who, in different words, claimed to be caught in a relationship for the sake of convenience or appearance. Four of these

women had children, two were currently pregnant with their first child and one was living in a same-sex relationship.

Of these seven, four had considered separation and two women had left their partners, but had felt compelled to return. One of these women felt this compulsion, 'for the sake of the kids', and the other woman because of the spoken and unspoken pressures in her group of gay women.

In common with earlier respondents, these women spoke of pressures on them to maintain a dull and unsatisfactory relationship. Some of them made the connection between the external pressures of society and, in the case of Robin, her inner compulsion to be 'seen to be doing the right thing'. Robin was expecting her first child and worked as a secretary. She was unhappy at work and her negative experiences in her relationship resulted in a sense of impairment:

> Things were going well for a long while, then there was all this trouble in me falling pregnant....we sort of grew apart. But, here I am, seven months pregnant, what choice do I have... I'm not pleased about it but I can hardly leave and become a struggling single mother - what would that prove? Everyone would be worse off.

The conviction, that separation would produce no winner, was also expressed by Kim:

> When I married my husband I was rapt - I looked up to him and respected him - he's years older than me....now I see him for what he is... But I've got two kids and no prospects for a decent meal-ticket, so I hang on in this relationship. It's a sort of brain-death, we've got nothing in common, except the kids.

While Kim expressed her frustration forcefully, others were less vehement. Although not denying frustration and boredom existed, Beth, 37, spoke about the absence of emotional support from her husband and her continuing disappointment about this:

> I don't think I'm expecting too much. While he's good practically around the house, with cooking and looking after the kids, there's not much emotional rapport between us. I'd like there to be more and I

> do find it frustrating at times....the kids make up for it....but its not the same.

Not having children to comfort her or a sense of compulsion based on a marriage certificate, Sheree nevertheless, stayed in an unsatisfactory relationship. She spoke of the convenience of having a partner and pressure to maintain a relationship among her circle of friends. Although Sheree had left her partner two years earlier, she returned after six months, and they have continued the relationship with no more real satisfaction:

> Jan and I have a comfortable arrangement, but it's pretty boring and stale... In our circle, everyone is partnered off, and if you're alone, you're a threat to your friends....in many ways its easier to hang on in many ways its easier to hang on in there than to do something radical.

These respondents led different life-styles, yet they all experienced an overwhelming sense of impairment, related to negative experiences of their relationships. The common denominator was entrapment in an unsatisfactory and unsatisfying relationship. For other respondents, the relationships in which they were involved were full of damaging conflict, some of which was related to their families of origin.

(ii) Damaging conflict

For three female respondents, all married and aged 36, 43 and 54 respectively, the conflict in current relationships was connected with past family influences. Despite some understanding of this and dissatisfaction, none of them had left the relationship, although all said they had given that option some serious consideration.

Margaret, 43, who worked as a part-time teacher, spoke of the conflict in her relationship because of her husband's excessive drinking. Their two children, aged 10 and 8 had suffered, according to Margaret, and this marriage reminded her of her life at home as a child:

> There's a lot of anger in our relationship, I get angry with Bob for his drinking and he gets angry because I remind him of it....it's shades of

> my mum and dad all over again. Yet, the funny thing is, there's also a lot of affection between us, but the heavy drinking is taking its toll.

Similar dynamics were occurring in the case of Elaine, aged 54. She worked as a part-time clerical assistant. Marriage had been coloured by physical violence. She said:

> Its hard to say why I stay, its like a habit now. But it can get really bad....like him hitting me and he used to hit the kids when they were small....my father used to hit me as a kid....but its only when my husband's drunk. Things are never hunky-dory, but when he's drunk, then its really on for young and old.

The conflict in these two women's lives was damaging, but they rationalised why they remained in such relationships. Being reminded of past parental relationships and having a sense of a current relationship becoming 'a habit', somehow guaranteed there would be no change. There was powerlessness and fatalism in their comments: an expectation that past negative experiences would always plague the present.

This sense of powerlessness was also expressed by Margie, 36, but in a slightly different manner. Her relationship with her husband echoed some experiences from the past but she was less fatalistic about her future. The conflict in her relationship related to her husband's attitude towards what he perceived as 'woman's role'. His attitude, reminiscent of her own father's towards her mother, represented what Margie considered an 'out-dated, sexist attitude to women'. She explained:

> There's a taken-for-granted assumption that I'm to remain at home, keeper of the home and hearth - I've made a few attempts to free myself, but my husband's attitude is not very liberated....we were missionaries in Africa for four years, and I had more of a role there. I now miss the teaching I did there....but my husband's opposed to me getting out, my place is in the home. His views remind me of my father's all those years ago. But despite the conflict over this between us, I'm sure things will change....it might be a long process but I intend to re-educate my husband!

Current relationship patterns reflected past conflicts in their families of origin. Although they spoke of powerlessness and feelings of impairment, there

was a connotation of immobility as well. Leaving a relationship, even one dominated by conflict, was difficult. Leaving might create more problems than it could solve. All three implied a fear that leaving the relationship might lead to an even more acute sense of depression.

(iii) Wanting a relationship

In common with the respondents described above in the caption 'no relationship and desperate for one', four women and one man said they 'wanted a relationship'. They held idealised views of relationships almost entirely as a result of a previous damaging experience.

As with those earlier respondents who viewed the absence of a relationship as contributing to their sense of impairment, these respondents were unhappy about what they perceived as their failure to meet a 'natural' and 'normal' expectation that they be 'paired off'. Despite these pressures, some of them were careful to convey the impression that it was not 'any old relationship' that they craved, but a certain type of relationship.

For instance, Miriam was born in Poland, but had spent most of her adult life in Paris, before migrating to Australia said:

> Of course I'd like to have a relationship....but I'm fussy now, not just anyone will do. We have to have similar interests....I don't like a lot of Australian men, they are not courteous or charming enough and they are preoccupied with sport.

For Meg, a 63 year old single pensioner, a relationship was also important, but only one in which there was mutual trust and support:

> I made the mistake of trusting a man I'd known or 10 years and he made off with my money... I'm wiser now and would know what to look for in a man, I'd be more careful.

Past bad experiences in relationships had made these respondents cautious. They 'wanted a relationship' but only under conditions, where support and trust would be reciprocal. Nevertheless, they still had the perception that not being in a relationship was contributing to their sense of impairment. The final group of

respondents found work and their social conditions contributed to their sense of depression, though they experienced relationships as an alleviating feature of their lives.

(C) Negative Experiences at Work and Negative Social Conditions

These nine respondents (five women and four men aged between 23 and 74) said that they felt impaired in terms of work and social conditions. The youngest, Claudia, was the only woman in paid employment. All the other women were aged pensioners and one 28 year old woman was receiving Worker's Compensation payments. Of the men, only one was employed, as a storeman. There was one aged pensioner and the other two were in receipt of Worker's Compensation payments.

Despite a number of differences in age, background, support networks and life-style, this group had common perceptions of what contributed to their depression. They were 'frustrated and bored' with their experiences of work, or the lack of it. They resented their predicaments, they expressed a feeling of hopelessness and powerlessness. These respondents were specific about what predominantly affected their poor self-esteem and their unfulfilled social roles. I have divided their responses into three categories, the first of which is 'frustrated and bored' with work.

Negative experiences at work

(i) Frustrated and bored

Both Lionel and Claudia experienced work as boring and were frustrated by the limitations their formal positions placed on them. In terms of promotion prospects, Lionel's age and Claudia's gender were perceived as 'going against' them. Claudia said:

> I'm ready to move on but they're not moving me on... I find that so frustrating....but what can I do? If I don't like it I can leave but I'd like to make a career in banking.

This sense of powerlessness in relation to a structure was also reflected by Lionel, who was unlikely, in his estimation, to ever make it 'higher' than his present position. He did not find much joy in his work and was jaded by his limited prospects:

> There's not much scope for me at my age, they're mostly looking to the younger blokes... I used to enjoy my work, but it's become boring....and now that I can't see any way of getting higher....well, I don't mind admitting its damn frustrating!

Both Claudia and Lionel felt trapped. The next three respondents not only conveyed this sense of entrapment, but were also explicit about other things.

(ii) Resentful of enforced retirement

The three respondents who were receiving Worker's Compensation resented being forced into 'retirement'. None considered themselves old enough or ready to 'retire', yet they could see little in the way of work prospects in the near future. Louise, a 28 year old kitchen-hand, who injured her back on the job eighteen months earlier, spoke of her increasing resentment at being at home, unable to work:

> I'm really cheesed off with being off work....I could go back to some light duties, but they're aren't any, and anyway, I'd rather work in a kitchen... I always enjoyed work, which is more than I can say for sitting around watching the soapies every day.

This frustration, the feeling of hopelessness and resentment was also expressed by Brian, a 49 year old salesman, who was knocked down by a car on his way to work three years earlier. Sitting at home he became increasingly dissatisfied and resentful:

> I don't know what hope there is, I'm not a pessimistic person, but I'm too young to be in virtual retirement. This is not my idea of the ultimate...I'd rather be working....I enjoy being with people and I was a good salesman.

Similar sentiments were expressed by Keith, a 54 year old clerk with repetitive strain injury, who had been on Worker's Compensation payments for

two years. The two men, in particular, expressed dismay with the medico-legal system which had them 'doing the rounds of doctors and lawyers, proving their incapacity and further being branded by the 'sick role'. Brian explained, 'the whole system is Catch 22 - you have to prove you're disabled, but they don't want to know how much you can do, just the disability - what you can't do'.

This labelling of individuals according to 'what you can't do' is institutionalised as people age. These respondents observed that they were damned by others: 'you either cannot' or 'you should not' do paid work. Yet they felt far more capable than such damning judgements implied.

The following respondents spoke about their sense of hopelessness and powerlessness when a cherished role was no longer available.

(iii) Hopeless and powerless

In keeping with the sentiments of the previous respondents, these people were unhappy about not having work. All of them were retired and receiving the age pension. They had all been active members of the paid work-force all their lives and retirement and brought with it a sense of being devalued and powerless. This powerlessness was epitomised by Pat, a 66 year old widowed woman who had worked as a legal secretary:

> When I had to retire, I thought it would be the end of the world....even now, five years later, I haven't altogether adjusted to the idea... It's the feeling of being inconsequential that worries me. I felt I was somebody while I worked.

Ben, aged 68, had also enjoyed a productive working life, and had felt physically able and mentally alert enough to continue working. However, he was 'forced' to retire at 65, a fact he regretted and over which he felt powerless. He said:

> I didn't like to retire I can tell you....it's a strange rule that forces a man into retirement even when he feels quite capable of going on longer. I knew retirement would be hell for me, but what could I do? My prediction was right, it is hell. But I still get up at the same time I did when I used to go to work, and then I have to fill in the day... When I first gave up work I sort of went through a mourning process.

Mourning the structure that work had given to their lives and the 'importance' that they felt as members of a workforce was inherent in the conditions of retirement. Their consequent feelings of hopelessness in their 'retired' position said a lot about how crucial the world of work had been to their identity, their self-esteem and thereby to the satisfying roles they were able to play in other parts of their lives.

These respondents had in common a lack of control over their fate. They felt constrained by a role they now found themselves in, but had not chosen. They craved the role that had given their life meaning. Having lost that role, they felt 'down' and 'sad', 'low' and 'lost' and continued to be highly vulnerable to depression.

The other common denominator for this group of respondents related to their negative perception of their 'social conditions'.

Negative Social Conditions

(i) Housing hassles: financial and emotional concerns

All the nine respondents reported 'being always worried', 'emotional' and 'emotionally stressed' regarding their poor finances and concerning their physical space. Rent or mortgage repayments were too high, incomes had dropped, including those who were on Worker's Compensation payments, which were only a fraction of their previous earnings.

Others, especially the older people spoke of the expectations - the 'hassles of having expectations' and 'expecting too much of myself' which were now tested and found wanting. For instance, Kathleen, 74, could no longer keep her house tidy and clean as she wanted to, neither was she coping well with the stairs. She had fallen, broken her hip and subsequently had a hip replacement operation. Despite these difficulties, she wished to remain in her home for as long as possible:

> It's bad when the house you've lived in all your life becomes a burden and obstacle to you... I worry about keeping it like I always have....I

> need to get help in now....and it's worrying when you have to keep reminding yourself about how steep the stairs are and wonder when you're going to take your next tumble.

The depression which another elderly woman suffered, had occurred, she said, not merely because she disliked her home. She had lived in accommodation in the past which she disliked. But now she felt trapped. Her home was no longer suitable for her needs. The thought of selling and moving was too daunting. She was a widow. Although she had supportive sons, she felt she had no choice but to stay in what had become a sort of prison. She explained:

> I hate the stairs, even though I'm on the ground floor, there are 15 steps to get up from the street. Besides, it's too noisy here for me now... I'd move if I could but it's not possible....the conditions I have to live under are all too much....but so is the thought of moving.

For these pensioners, the thought of remaining in their present accommodation was stressful not merely unpleasant, yet they had no choice. Respondents in receipt of 'fixed income' like pensions and Worker's Compensation benefits had no financial means. Two men on Worker's Compensation payments wanted to renovate their homes but their finances did not permit them to do so. Brian summarised the oppressive nature of financial constraints:

> I sit here and dream of all the wonderful things that could be done to this house....but without any money it'll have to stay in its present lousy state. There are lots of things which really need attention and the house will crumble around our ears if we don't do some repairs shortly.

For the woman respondent on Worker's Compensation payments, there was an even more basic concern: meeting the rent and dealing with an apathetic landlord. Her husband was an unskilled labourer, the rent had risen and the landlord was unco-operative about water damage to the property. Louise faced financial concerns as well as the emotional consequences of feeling powerless in the face of a 'domineering and indifferent landlord'. She commented:

> The place needs so much work, especially where the storm damaged the walls and floor - there was a flood in the back part of the house during the last storm,- but the landlord doesn't give a fig... I've tried to interest him in doing something, but he just raised the rent instead!

Dealing with difficult and inconsiderate landlords and the feelings of frustration and powerlessness which ensued was also the experience of two other respondents. Whether the difficulties in their social conditions were related to meeting the rent, convincing landlords to take remedial action or dealing with the frustration of not being able to maintain a home, or cope physically in it, these respondents all believed these circumstances contributed to their sense of depression. More specifically, their social conditions were inherent in their depression: their identity was tied up with the physical and social connotation of where they lived. In almost all cases these conditions represented a marked deterioration from their previous experiences, hence the dislike and disapproval of their current identity.

Vulnerability: an imbalance of negative and positive experiences

The group of 43 respondents who had been labelled 'highly vulnerable' have spoken out on what they believed contributed to and alleviated their sense of social functioning. Their experiences were compartmentalised into the world of work, relationships and social conditions, but the overall picture is more complex. The full story of these individuals' depression concerns interrelationships in context: an interdependence of experiences in three areas of the respondents' lives.

Respondents perceived their experiences as largely negative. Each respondent's **perception** of an imbalance of negative and positive experiences produced a sense of vulnerability. They could have identified with Hamlet's contention, 'There is nothing either good or bad, but thinking makes it so' (Hamlet, Act 11, Scene ii).

Some respondents who lived in humble homes and were in financial difficulties did not perceive these circumstances to be contributing to their sense of impairment. These same respondents perceived an unsatisfying relationship and work pressures as the really negative experiences.

The complexity of the interrelationships between the three areas of people's lives is difficult to convey but several themes emerged. First, in the area of work,

the 43 respondents were grouped according to a number of patterns. With regard to their perceptions of the world of work, and associated sense of identity, they expressed powerful positive and negative emotions. The respondents were saying that they disliked feeling hopeless, powerless and undervalued. Those who were not in paid employment missed the important ingredients of believing in what they were doing, the recall of enjoyment of work, the sense of hope and control over their work place and even 'my future' and 'destiny'.

Secondly, in the area of inter-personal relationships, the issue and patterns came down to three principal concerns. There was an overwhelming feeling of debilitation from those involved in relationships which were unsatisfactory and unsatisfying, and where there was damaging conflict. Relationships which were physically and emotionally draining were also perceived negatively. Lastly, those respondents who did not have a current relationship perceived that state negatively. Every respondent, irrespective of which particular theme they enunciated, either stated or implied some awareness that external pressures were operating either in their apparent willingness to continue in an unhappy union, or if they were alone, their desire to have 'some sort of relationship'.

Thirdly, with regard to the area of respondents' perception of their social conditions and expectations, there were a number of similarities across the groups. Each respondent's sense of self was woven into their perceptions of social conditions. At a physical and material level, there was a group concerned about housing and their struggle to meet rents and mortgages. Then there were those for whom there were conflicts and contradictions between their social values and expectations and what they perceived as society's wider strictures and mores. This group shared something in common with the group (all migrants) for whom the prevailing social conditions in Australia meant a tension, a dilemma, a cultural clash, a constant sense of wanting to hold onto a culture left behind. In these respects these (43) respondents felt socially impaired and were highly vulnerable to feeling and being depressed.

CHAPTER 9

NOT SO VULNERABLE

The label 'not so vulnerable' suggests that the respondents who identified only one area in which they felt they could not function as they wished, were better prepared to ward off depression than those who identified two or more negative areas. Yet the major task of a researcher, a social worker, a general practitioner or other prospective helper is to probe beyond surface appearances. Positive areas of social functioning may not compensate for the impairment experienced in one area.

As with the previous groups, addressed in the previous chapters - 'no relief in sight' and 'highly vulnerable', - the major task of analysis is to examine the relationships between the experience of depression and the alleviating or contributing conditions. The thirty one respondents whose experiences are discussed in this chapter had two things in common. They only identified one negative area of experience, hence the label 'not so vulnerable'. They identified two areas of their lives as positive, as helping to alleviate their depression.

The combination of positive and negative experiences, two of one kind, one of another, was as follows. There were 16 respondents who explained that it was in the area of personal relationships that their experiences were negative. There were eight respondents whose experiences in the world of work were negative. There were seven respondents who said that their social environment was the debilitating feature of their lives. That combination of positives and negatives is displayed in Table 9.1. The same figure also shows the gender and marital status of this one negative, two positives group.

Table 9.1: Negative experiences of the not so vulnerable

	Gender		Marital Status			
	M	F	Married	Divorced or Separated	Single	Widow
Negative Experience of Relationships	6	10	8	2	2	4
Negative Experience of Work	4	4	8	-	-	-
Negative Experience of Social Conditions	-	7	4	-	-	3
TOTAL	10	21	20	2	2	7

Although the main purpose of analysis will be to identify what the respondents meant by experiences which contributed to depression, the distribution of the 31 respondents into these separate sub groups merits some attention. For example, more than half of this group identified negative experiences in personal relationships as debilitating. Of those who identified this negative experience, an equal number of respondents were married and currently not married (Table 9.1). There were eight people who were married and of the other eight, two were divorced, two were single and four were widows. The link between these different marital statuses and the negative experiences of personal relationships will be explored later.

With reference to the negative experiences of the world of work, it is worth remarking that men represented half of this group even though they represented only a little over one quarter in the sample as a whole. Of the group of seven who spoke of their negative experiences of social conditions, all were women, four of them married and three widows.

As with the previous unravelling of the combinations of positive and negative experiences, each of the separate areas of social functioning will be addressed before the question of the relationship between alleviating and contributing conditions is posed. Those respondents who referred to negative relationships will be examined first.

Impaired Functioning in Relationships

The connotation of the label 'depression' suggests a probable difficulty and a possible failure in relationships with members of a family, or with other significant and close intimates. If that connotation is valid it is perhaps surprising that some respondents felt debilitated by depression yet insisted that in the world of close relationships they felt their life was positive, or as positive as it could be. Nevertheless the point about the sixteen is that they insisted that this was the sole issue which eroded their self esteem and had an ill affect on their ability to cope with other areas of their lives.

Among the sixteen, the negative experiences in relationships displayed three distinct characteristics. There were those who once had good relationships and who experienced loss through death or sickness of a partner. Secondly, there those whose current relationships were damaging in different ways. Thirdly there were those whose negative experience was tied up with their sense of their own identity rather than with any specific conflict with others. These three groups, depicted by the concepts loss, damage and identity will be discussed in turn.

(i) The issue of loss

The loss of a husband or wife through death or the loss of a partner in the case of an elderly single woman were events to which these respondents had not felt able to adjust. They were still grieving. They characterized themselves as preoccupied with their absent partners, in some instances idolising them more in death than they had in life. Gwen was a widow aged 62 whose husband had died one year before the interview. On that occasion Gwen explained, 'I suppose I was dependent on him though we did make decisions together. I now have to make important decisions myself'.

An almost identical account of the consequences of the loss of a husband was given by June who was 65 and whose husband had died sixteen months previously. 'He could be moody and hard to live with but he was my main confidante. I desperately miss his male presence. We had such a happy relationship'. June also observed that a close female friend had been 'very

supportive' but this friendship could not compensate for the loss of her husband. 'But if it was not for her I would have fallen apart when Frank died'.

The pain of irrevocable loss and the difficulty in moving into a new role following that loss was a common phenomenon for widowers as well as widows. Len explained that he had been happily married for 38 years when his wife died two years ago and he had been 'desperately lonely' since that time. 'She was wonderful and I miss her very much. I am so lonely sometimes I talk to her. She was gracious and giving. It helps me to talk to her. I have to learn new things. I suppose I was spoilt. I have to learn to cook and clean, almost a crisis in itself'.

The widow and widower whose reactions have just been referred to had some friends and some family available to them, though in one case (Gwen) there were no children and in another (Len) his children lived hundreds of kilometres away in Brisbane. But in the case of migrants who had come to Australia late in life, the prospect of isolation following the death or hospitalization of a close friend seemed as certain as the struggle to find new friends on their arrival. Nadia, for example, was a 76 year old white Russian who had been born in the USSR, had migrated to China and then to Australia. She had always lived with and cared for her sister with whom she had shared the struggles of travel and migration. The sister, eight years her senior, was now bed ridden. This dependent state of her sister would have been nothing new for Nadia except that Nadia's health was also worsening. She was almost immobilized by arthritis and the managing, caring relationship which was the predictable role in relation to her sister and which had provided her with her sense of identity, looked as though it would no longer be possible. It was not merely a new role but the powerlessness associated with no significant role which faced her. Between tears she explained, 'I am even more low. I'm afraid I won't be able to walk shortly and I'll be like my sister. But no-one will be able to look after me. There is no-one when I cannot do it'.

Nadia and her sister had no relatives in Australia and none left overseas. In these respects they had something in common with the experience of 'the lost people' described by the younger Russian men whose experiences were recorded in chapter seven under the caption 'no relief in sight'. But there was some relief and comfort for Nadia and her sister. Nadia still felt able to do some cleaning and

some shopping. In that respect she said that the inability to go to work was not contributing to her condition. They owned their own home, had lived in it for twenty years and had contact with other Russians in that locality. Their contacts were maintained through their Russian Orthodox church, a cultural hub for them and one which fulfilled an important supportive function for many migrants.

The examples of unmanageable loss have so far referred to people in their sixties or over. The same sense of loss could also be experienced by someone much younger. Trisha had been widowed at 36. Now, a few months later she was depressed, though she contended that her husband's death from asthma had been just one of several losses that 'are heaped on me. I don't know how I manage to live with it all and remain as sane as I do'. This was a reference to her mother's recent death from cancer and her own increasing sickness with asthma. She felt that her mother had wanted her to be independent and strong and now that opportunity had arisen under circumstances that made it difficult to be either. 'Well now I can really be independent can't I? After all I've got absolutely no one left in the world to rely on or to have rely on me. So I guess I've really made it. The independent woman!'

Another group of respondents who attributed their sense of depression to relationship difficulties did have people whom they might have relied on and dependents who might have relied on them, but their current experience of relationships was characterized by conflict rather than by the recall of happier times which had passed.

(ii) Damaging conflict

Partners in marriages which had turned sour but from which they felt there was no escape expressed themselves worn out and depressed by the constant sense of conflict or total indifference. In at least two cases the conflict was compounded by the drinking problems of one or other partner. Helen a 46 year old mother of two explained 'he gets drunk and I get depressed'. She recalled that this drunkenness was also a lasting memory of her childhood when her father was 'worse for wear with drink'. As if to ensure some continuity of damaging relationships she said she felt out of touch with her ten year old son and he was

'clashing with me'. She adjusted to such conflicts by working harder than usual in her job as a salesperson and by trying to get as close as possible to her eight year old daughter.

The precedents of conflict and the events which provoked the resort to alcohol were not a generation old in the case of Mick a Vietnam veteran. His story was that after returning from Vietnam he had ceased to be the happy go lucky person who had left for war. He described himself as now given to moodiness, irritability and wanting to withdraw from company. 'I now have real difficulty being warm and caring and throwing myself into relationships. I have a wariness with people and less ability to trust or care fully for others'.

He said he realized that he had become difficult to live with, had resorted to drinking when he felt depressed but this made his marriage relationship even worse than it was already. 'I know I'm hard to live with. I put a lot of it down to the war. We have a lot of arguments and I know I get on Liz's nerves. My drinking even gets on my nerves but it has become an addiction. I need to drink to get through life'.

Work as a public servant was a safety valve for Mick. He said:

> Work is my life. It provides my reason for being. I don't enjoy the rest of my existence that much. At work I am not so irritable. I get on with people better. I still have my moments but people don't find me too hard a task master. At work I take on a different role. I don't have to be me, so to speak.

Mick saw himself as very different pre and post the Vietnam war. It was the consequences of that experience, in particular the abrupt change from soldiering in the jungles 'where I was someone' to the safety of suburbia 'where I was no-one'. His sense of integrity was restored at work in a job and a role he enjoyed. It was the role of being himself that he did not enjoy playing.

The issue illustrated by Mick was manifest in a marriage relationship but the source of the conflict lay elsewhere. In several instances the depressed adults in their middle thirties and forties were fighting a battle with a parent. Their marriage partner suffered the consequences of such fighting. The vulnerability to

depression lay not in an incompatible relationship with a husband or wife but in the unresolved conflicts with a powerful parent. Such issues were 'unresolved' because there had been few if any opportunities to talk about such issues. Craig aged 32 talked about his damaged relationship with his wife by reference to his father:

> An arrogant, pushy bastard always pushing me more and more. Having high standards, high expectations and coming down like a ton of bricks if I failed to live up to his dreams. I have always had an intensely ambivalent relationship with him. You could say I love to hate him. I want to impress him but then I think to hell with the bastard. He was tough on me as a kid and after I dropped out of medicine, I was persona non grata.

As a solution to his difficulties with his father, Craig had usually relied on alcohol and now had what he described as a drinking problem. He had become depressed over this and with the realization that if this continued he was unlikely to be much of a father to his six month old son. He had left his wife but had returned following a trial separation. 'I tend to lean on her, use her for confidences. I can't blame her. She finds me difficult. I'm pretty ugly when I'm drunk. Not that I have physically abused her but my emotional abuse is bad enough'.

Unresolved conflicts were also an issue for forty-one year old Chris whose second marriage was becoming a repeat of his first. He thought he knew what was happening but was unable to do anything about it. He said:

> 'I'm in a Catch 22 situation. I want to be a father to my kids but she sides with the kids and does not give me a chance. We have lots of arguments. It is draining and that's the beginning of the end. We say things we don't really mean and would not say if we were more calm. Then it is a slide into bitterness and hating one another'.

Chris explained that if it was not for his depression no-one beyond the family would know. They had a good home in 'a nice middle class neighbourhood where the calm and gracious facade masks the tension and turmoil beyond the white picket fence'.

In two cases in which the depression was explained by reference to a currently damaged marriage relationship, the issues were to do with predicability rather than turmoil, with boredom rather than conflict. Glenys was 36. She explained that she had had an affair and this was known to her husband. There had been controversy between them for some time but now they had settled into a routine bound in some sort of union by common interest in their small daughter. Glenys explained, 'There is not much trust. I don't think he has forgiven me for the affair. I am still attracted to my former lover but to see him again would be a recipe for disaster. But this relationship has become boring. The very boredom is stressful'.

As in the case of Craig, the damaged and damaging marriage relationship somehow seemed to reflect difficulties in childhood. Glenys talked about being sexually assaulted as a child and her own difficulty in speaking spontaneously to her mother about that sensitive issue or any others. Now with her eight year old daughter she felt that family unhappinesses were being repeated, not by incidents of sexual assault but by damage in other ways: a demanding mother and a disinterested father; a suspicious husband and a boring marriage; a desire to be a perfect mother for an eight year old child whom she felt she was letting down. Given her biography to date, the perfect mother role seemed beyond Glenys not least because she said she was striving so hard. Others who experienced relationships which contributed to depression, were striving to overcome several issues associated with crises of identity.

(iii) Issues of identity

Although the label 'depression' suggests people not being at peace with themselves, only two respondents in this group insisted that it was their unease with themselves rather than any damaging relationship with others which was the issue. Being uneasy, even disliking themselves appeared in various issues of identity. For example, Chris aged 56 had divorced following his acknowledgment that he was gay. Although this declaration gave him one sense of freedom, it posed new problems. He recalled, 'I was low and probably depressed for long periods as an adolescent when I realized that I was probably different from my brothers and sisters and most of my friends. I tried to account for this by telling

myself, in the same way other people did, that I was introspective and thought about things deeply'.

This thinking about things deeply had become a preoccupation with regard to his homosexuality. He observed that after years of 'good marriage appearances' he was now not sure who he was or who really liked him. There were three issues to be resolved. None seemed capable of solution. His relationships with his parents had been 'complicated and complex' but they were now dead and he regretted that he had not been able to talk things through with them. His relationships with his children were at best ambivalent because, with the exception of his eldest son now 28, they were unsure how to respond to his sexuality. His wife would no longer speak to him 'even though we have three children as testimony to the fact that for thirty years we got on very well'. Her reaction and the attitude of two of his children, plus recall of the depressions of his adolescence made him feel, 'If I had my time over again I wouldn't choose to be the way I am. It is nothing but trouble'.

The third issue which seemed incapable of solution concerned Chris's failed relationships with his male lovers. He thought he was 'only a superficial lover, very romantic and liking physical love. I prefer it in some ways to companionship but when my last lover walked out on me it really hit me like a bomb'.

Although Chris was materially well off, had a senior company position which gave him autonomy and the appearances of friends and friendships, he felt he lived in a society in which it was impossible for him to express certainty about his sexual preferences. The role change which had taken over thirty years to materialize was still not the one which he played with great enthusiasm though he wanted to. The brothers and wife and children whom he was once close to no longer wanted such closeness. He described his continuing crisis of identity in the comment, 'I really need the physical as well as the emotional, the masculine and the feminine spread in myself and my lovers. I have the material things and my emotions to share. I've got everything except my sanity'.

Another identity issue and perhaps a common one in a culture which promotes ideal images of marriage and the successful family, concerned the status of being single. This was expressed by Rosemary a 24 year old teacher who explained that when a very close relationship with a boyfriend had broken up, 'I was so depressed I stopped functioning. I remember just going on at the time but I really stopped functioning. I'm probably coming out of it now but I still feel low and unhappy'.

At her age and despite her satisfying employment as a teacher, Rosemary felt the stigma of being single and disliked herself for failure in that last relationship. She constantly blamed herself for what had occurred and she found herself always making excuses for her previous lover. She had avoided telling people what had occurred because her image of herself when she had been with her lover had been acceptable and her present status was not. She needed support from others but found it difficult to talk openly about her predicament. She thought she had accepted the loss of love for the previous lover but her friends and associates were not 'singles' and she disliked herself for this. She added that in terms of privacy it had some advantages. 'My problem is being single when everybody else is paired off'.

This fear and dislike of being single was also explained by Rosemary with reference to her own parents' broken marriage, the family's migration to Australia from Britain and the recollection of a childhood and adolescence in which 'something was missing'. The guarantee that she would obtain consistent support and other forms of satisfaction from close relationships and 'would not be hurt' was the ingredient which had been missing in her childhood. Now she felt it was missing again but it was her fault, her identity, her failure which was the issue.

Negative Experience of Work

Among those who insisted that their experience of personal relationships was satisfactory but their current depression was associated mostly with negative experiences of work, were four men and four women. Their explanations as to why difficulties associated with work were inherent in their depression were not divided solely along gender lines. There were men and women who had retired

and whose previous satisfactions had been closely associated with their employment. For example, an elderly man had been retired for over fifteen years and described himself as not yet ready for retirement.

The explanations of negative experiences in the world of work were of two kinds. There were those who felt trapped in their current employment. There were those who had once had satisfying employment but who felt that their prospects of returning to that former rewarding state were non-existent.

(i) No prospects

Anthony recalled being depressed as a youngster because his father had been demanding and he felt he could never satisfy him. This comment about his father he related to his current dissatisfaction with his career as a teacher:

> My father was the sort of man I do not want to turn into. He was hard and strict and I remember feeling hemmed in and frustrated. Not loved and having lots of negative feelings towards him as a child. Now I'm in a school where the Principal is hemming me in, watching me to see what the performance element of my work is like. It might sound unreasonable even to be depressed over this but he has a negative perception of me and I can't turn it around.

Anthony explained that he wanted to be successful in employment but after several years as a teacher he felt it was a 'dead end career - I once had all sorts of ideas but the system is flat. It stops you from being innovative. I feel guilty about not being innovative but what is called for is systematic, dull, routine teaching not creative new ways of inspiring the kids'. Anthony also said that the lack of career prospects and the current difficulty with the father-figure Principal were also tied up with the fact that the low salary meant that at home he spent too much time absorbed with bills and with ways to meet them.

The feeling of 'being in a dead end career with few ways out' was also the complaint of Graham, aged 54, who had been on shift work as a psychiatric nurse for years. He described his work as 'low pay for huge effort, very demanding, very draining, very sad and tremendously stressful'. He also contended that he and his wife had little social life on account of this type of employment and the hours he

kept. 'I work on Saturdays and Sundays and have Tuesdays and Wednesdays off. That means I am out of step with the rest of the world'.

When the idea about 'being out of step' was pursued, Graham also revealed a history of depression in his family and in his own life. His mother had committed suicide and his father had attempted suicide. Graham managed his own experience of depression and fear that it would be repeated by taking tri-cyclic anti-depressants. He referred to his vulnerability with detailed comments about his family's medical history but he emphasized that it was his work which 'prevents me from being a less irritable, more satisfied human being'. He said 'I have worked irregular hours for years and barely seen my sons grow up. At my age I'm now stuck in this job'. It was a job which dominated his consciousness, controlled his social life and constantly reminded him 'There is too little humanity in this society'.

(ii) Past job satisfaction

The feeling of nowhere to go was not only experienced by employees who felt that their present employment was a poor reward. It was also the feeling of those who had been obliged to take on part time employment but who recalled previous job satisfaction when they had been full time workers. Ill health and old age were the reasons for this shift from full time to part time employment.

Susan was Indian and before marriage to an Englishman had had what she described as a romantic career as an air hostess, 'with money, status, travel and clothes'. On arrival in Australia she had obtained employment as a clerk and then as a 'marker' with a clothing retail company. Some of the work had been heavy and repetitive but she had enjoyed the association with colleagues. Then she experienced back pain and pains in the arm. She had lengthy periods off work and was currently on workers' compensation. Management had shifted her to part time employment and a less physical job but she felt that management and her colleagues did not believe that she had repetitive strain injury. The pain and the half-time work restricted her whole life-style. Wherever she looked there was disappointment over what might have been:

> The management don't seem to believe me that I have back problems. Co-workers give the impression that I'm getting off lightly. I have to hold in my anger and that is very stressful. I have to fight a long legal matter to prove that I'm in pain and that the pain came from work. yet I want to return full time. I can only think of previous glamorous jobs. But if you're a woman and an Indian and married to an Englishman in Australia, the future is bleak.

The disappointment with not being able to work full time and obtain the social and financial rewards for so doing was also described by Charles, an 80 year old who saw himself as a 'battler'. He had left school at 13, and had served an apprenticeship as a motor mechanic. For thirty years he had been a foreman in an assembly firm. He had prided himself in always working, always trying to better himself and other people by doing odd jobs in his own home and in other people's homes. The odd job fixer was how he saw himself and how others saw him. 'I used to fix people's cars, sinks, washing machines, refrigerators, almost anything that needed repairing. My hands still work so I try to use them. I don't like being idle'.

Among the people he had most cared for in his life had been his wife but she had been diagnosed two years previously as having Alzheiemer's disease. This huge problem had defeated him. He said his love for his wife remained and he would not say that negative relationships contributed to his bouts of depression. People no longer wanted him to do their odds jobs and his wife was in a nursing home so she made no direct demands on him though he visited her every day. He explained the contrast between the constantly busy satisfaction of his career and his current changed status and outlook:

> It's not easy after you've lived with someone for 43 years to be separated under these conditions. It has been a dreadful strain. The loneliness is hard to live with and the knowledge that my poor wife doesn't really recognize me, can't really respond to anything any more. It's awfully depressing to see that happen to someone you love and care for. I used to fix things. I'm helpless to do anything to help her. I visit her daily but I wish I could make her better somehow. I know all that is impossible and that is what is depressing.

In common with others who remembered their previous days of employment as having given them a positive outlook on life, Charles concluded that he knew he could never work full time again, not even for neighbours or his wife. Current

powerlessness compounded by recall of what used to be made him 'fight most days to keep my head above water and avoid getting that sinking feeling'.

Negative Experiences of Social Conditions

Among the group of thirty one, the seven who described their social conditions as impairing themselves and their lives were all women, three widows and four who were married. Their gender and marital status appeared to explain their current negative experiences with social conditions. Expectations of behaviour associated with being a wife or being a wife and mother could not be realized and control over a key feature of their lives, their housing, was not possible. When these explanations were pursued it was apparent that the notion 'social conditions' was tied up with people's sense of themselves and thus described far more than a set of material factors. The 'material factors' often turned out to be cultural and psychological and just as tangible as if people had referred to physical conditions alone. In pursuing the respondents' explanations, two issues were apparent. The first concerned disappointment with status in a particular context. The second referred to the powerlessness associated with the struggle to find somewhere congenial and affordable to live in an increasingly expensive city.

(i) Disappointment in context

Ruth was a thirty two year old general practitioner who had spent a lot of time reconstructing the factors associated with her bouts of depression. She was happy being a general practitioner and as her husband also had secure, well paid employment they had no difficulties with housing. She described her family relationships as uncomplicated and supportive but the conditions associated with her inability to conceive provided the context if not the cause of periods of depression. She commented that the word 'periods' was apt. 'When my period comes I feel very disappointed and irritable'.

Ruth explained that originally she had not realized the social pressure she had placed herself under in an effort to conceive. It was as though someone in her job, of her age and marital status was being deviant for her failure to have

children. She developed a depressed point of view about her immediate social environment: childlessness became virtually the key constraint:

> I had an overwhelming feeling of hopelessness and was not motivated to do anything and it began to worry me when I felt I was not motivated to work. It's definitely a reactive depression. I ought to know about it. At another level too I find myself having difficulty in understanding why some women suffer post-partum depression because I would consider the prospect of having a baby nothing but a joy.

The idea of women being disappointed with reference to a specific aspect of their lives was expressed in tandem with observations about actual physical living conditions being satisfactory. Freida, a widow, felt marooned in a 'very pleasant' old people's home and Patricia said that as a migrant to Australia from Canada and New Zealand she was not dissatisfied with this new country but dissatisfied that 'socially I'm nobody once again'. Freida felt that her children had persuaded her prematurely to go into a home, 'They thought I could not manage. They want the best for me but I could have stayed in my own home longer'. Patricia said that as a three time migrant, from England to Canada and from there to New Zealand and then to Australia she should have known the potential for disappointment but had not expected it to be so acute. She supposed that as she was in her late fifties the shock of this change - something like Toffler's Future Shock - was more difficult to adapt to than when she was younger. Her expectations of herself remained the same but the constraints under which they might be achieved were foreign again and gave the feeling that they were insuperable.

These interpretations of individuals' sense of themselves being constrained by unrealisable expectations in a particular social environment were not so apparent among those women who hoped for a home of their own which would give them satisfaction as mothers and home makers. Their comments about social conditions contributing to depression concerned mostly the immediate material environment.

(ii) Homes beyond reach

Jean was also a migrant. She had come to Australia from Lancashire, England thirty years previously. She and her husband had worked hard and in their middle fifties had set their sights and their hearts on a particular property. They thought they had secured the property with an offer which they could just manage but during the transaction they had been gazumped. Now the house prices had outstretched their means:

> As I'm the worrier in the family it has all fallen on me. I've had difficult conditions before, like in the disgraceful migrant hostel when we first came here but then a year ago I really wanted this home. When we did not get it my health went into a nose dive.

Jean had health problems which were not directly associated with the disappointment of a home which was now beyond reach but she said that these other difficulties 'I could regard as normal at my stage of life'. The cheating associated with the property transaction, or rather the non-transaction had been different from other stresses. This time she felt an unfairness mounting almost to an undeserved punishment for someone who had tried so hard. Even at the time of anxiety over the discovery and removal of a small lump from her breast she had not felt so enveloped in a feeling of being shut in or, she said with a wry smile, 'in our case shut out'.

The expectation of a home of one's own sharpened with several women once they became mothers at which point they became concerned over the environment in which to bring up their children. Julie Ann had not been too bothered about the rented property which she and her husband shared in the early years of their marriage when both were working. Now with a four month old baby, the change in role, the decline in income and her increased awareness of the 'misery of this one bedroom apartment' had given her a feeling of hopelessness. She added that she was pregnant again and that her G.P. had referred her to a psychiatrist for counselling. The psychiatrist had asked no questions about the type of accommodation she was living in or the kind of home she would like to have. 'He was about as useful as having tits on a bull'.

Julie Ann's vulnerability to depression was not merely the product of the intense disappointment with her present surroundings. She recalled a physically cruel relationship with her father in a childhood which she remembered as sad and punctured with 'really proper hidings from dad, not because he was drunk but because he was a proper bastard and violent'. Her relationship with her husband was very supportive and he was her sole support, 'the best of friends'. In this respect she had high hopes of producing a family life which in every way would not be a repeat of the past. Yet the roof over her head and the same one which covered other young mothers was not what they wanted and was hardly a home. She felt she was one of thousands in a similar predicament:

> The social conditions under which young mothers live in suburban Sydney is depressing. Here it is isolating, lonely and almost unreal. You can go a whole day not talking to another adult until your husband arrives home at night.

Apparently not so vulnerable

This chapter began with the contention that respondents who identified only one area of their lives as contributing to depression would not be so vulnerable to that illness as those who identified at least two negative areas in their lives. But the intensity of a difficulty associated with any one area could outweigh the positive effects of life being seen to be manageable in other areas. For this reason, when identifying respondents who experienced only one specific debilitating condition it would be more appropriate to describe them as 'apparently not so vulnerable'.

The reference to a 'specific debilitating condition' is also misleading. The relationship between alleviating and contributing conditions showed the interconnectedness between apparently discrete areas of life. It is this interconnectedness which illustrates both the nature of social context and the meaning of depression for these respondents. In terms of diagnosis or treatment it would be inappropriate to overlook that interconnectedness. Paradoxically, the best way to depict it may still be to question people about discrete areas of their lives and in the first instance to document their explanations under specific headings and with regard to apparently specific problems. At the end of this

chapter it is the issue of the relationships between one negative and two positive experiences which needs to be summarized. Such interconnectedness was inherently difficult to trace in that intriguing area referred to as 'interpersonal relationships'.

Difficulties in interpersonal relationships were experienced by far more respondents than the sixteen who said that this was the one area of their lives which created difficulty. Numerous respondents indicated their vulnerability to depression because unresolved conflicts in relationships with parents and, less often with children, lay not far beneath the surface. Although their present relationships were said to be satisfactory, they had invested so much in them because they did not want a repeat of their childhood or family experiences. The connections which were being made concerned the desire to make amends for a past, to consolidate current positive experiences so that they could avoid a repeat of childhood unhappiness, cruelty, sexual abuse and drinking problems. Their previous experience of such difficulties was connected to their desire to succeed in the present. In this respect such respondents were far more vulnerable than appeared at first sight. For example, the man who suggested that his depression was tied up with a dead end career was also fighting to prove wrong all the things which his strict, authoritarian father allegedly said about him. The young woman who had been abused as a child wanted her home to be perfect, materially and emotionally in order to provide her young daughter with a far better childhood than her own. Personal growth and development was tied up with feelings about immediate social context and with wider social expectations.

The wider social expectations and conditions were apparent in some of the stories of difficulties in maintaining relationships. Their homes were in Sydney in the late 1980's. Some relationships were difficult to maintain because distances were vast and travel expensive. Having children in Brisbane if you lived on a pension in Sydney was to have a promise of direct contact remaining unrealised for years. In addition to the problems of expense and distance, the anonymous nature of the urban environment and in particular the anonymous flats in look-a-like housing blocks compounded other negative experiences of individual and family life.

Even an apparently discrete area of life such as work could not be considered in isolation from country and context. Some of the apparently not so vulnerable men in the group of ten described in this chapter were high risk candidates for depression because they shared the expectations of their culture and wanted identity, status and financial reward from their employment. When it failed to provide any of those things, an immediate feeling of unworthiness was added to their forecast that the future held little hope. Only if satisfaction could be obtained from other areas of life besides work could the sense of foreboding be lessened. Children, spouses, friends, cultural and religious activities might provide those other forms of satisfaction. That was an issue for all respondents and of particular pertinence for those who were migrants.

PART IV

THE MEANS AND MEANING OF TREATMENT

CHAPTER 10

DEPRESSIVE CONDITIONS FOR DOCTORING

The terms 'no relief in sight', 'highly vulnerable' and 'not so vulnerable' have been used to describe the circumstances of three groups of respondents in the total sample. These descriptions have a social as well as psychological connotation. When these descriptions were unmasked, they also showed financial, cultural and religious issues affecting people's perception of themselves and the quality of their lives. In my interviews with the general practitioners who worked in the same neighbourhoods as these 80 respondents, explicit comment about matters of social context was unusual, though many identified the 'low mood' nature of depression, and the vulnerability of particular groups. They did so as much by reference to the depressing conditions of being a doctor as to comment on the difficult circumstances of any individual patient.

Doctors' descriptions of the nature of depression, the characteristics of depressed patients and the conditions which affected their response to such people, is included as part of an analysis of social context overall. These general practitioners are included in such a context in part because researchers have identified their gatekeeping function (McCaughey et al 1977; Huntington, 1981; Mullaly 1988). For example, although only a small majority of respondents in this sample said they had sought help from their general practitioner as their first step in seeking treatment, almost all said they would usually regard a doctor as a first port of call if they thought they were ill. In this respect a doctor could have considerable influence over the steps towards recovery which an individual might subsequently follow.

This chapter will show that even if doctors were interested in treating depression and felt they knew about such a condition, the organisation of their general practice and in particular the fee for service method of payment, made it difficult to find the time that was necessary to make an apt diagnosis, offer treatment and continue to provide it. If doctors were not interested in such a

condition, the very constraints of their practice gave them further reason to be disinterested.

Whether doctors were or were not interested in patients who felt depressed, and in the circumstances which were associated with such a condition, the patients who visited such doctors would be affected. Some of the circumstances affecting the conduct of some general practices were as constraining, virtually as depressing as other difficult conditions affecting people's lives.

Doctors' assumptions and beliefs

These doctors' accounts of their practice begins with their views on the nature of depression. My interviews with them posed the questions, what is depression, who gets depressed and what causes such a condition? Subsequently I discussed the ways in which their own practice affected their interests and assumptions about the treatment of people suffering from depression (see Appendix 5).

In answer to the question, 'what is depression?', the doctors displayed their certainty that this was a complex condition which could be defined in several ways. In explaining their definitions, some referred to their resentment over the uncritical use of the word 'depression'. A young, male doctor explained, 'I think depression is one of the most misused words in the English language and sometimes it is overused. Most people use the word interchangeably with unhappiness'. In his view depression was an emotional state which was different from unhappiness, but there was an overlap. Not all the people who were unhappy were depressed but almost all depressed people showed that they were unhappy.

Although responses to the 'what is depression?' question produced all sorts of examples, two trends emerged. They all defined depression with reference to physical and psychological or emotional symptoms. Some doctors emphasised a physical and physiological explanation, others highlighted the importance of psychological factors. Secondly, all the doctors qualified their views of depression by referring to types of depression and to the severity of the condition. Several

differentiated between 'reactive' or, in their judgements, 'neurotic' types, and 'endogenous' or 'psychotic' manifestations. Others did not use these distinctions but spoke of depression as being 'a matter of degree', 'from mild to severe'.

Of the doctors who said they gave equal weight to physical and psychological explanations and who said they were therefore prepared to identify either type of symptom, an elderly male doctor explained:

> Depression has somatic and psychological and emotional manifestations. Physically, depression is reported as tiredness, sleeplessness, fatigue, headaches and other vague aches, loss of libido, appetite disturbance. Psychologically and emotionally people report feeling low, confused, anxious, worthless and insecure.

A 32 year old female practitioner expressed a similar point of view:

> Depression is a set of symptoms. Sometimes it's the physical side that is more important, sometimes the emotional aspects. I always suspect depression when there are disproportionately severe or annoying symptoms which have no apparent physical basis. Things like feeling giddy, vague aches, head and neck pain, sleeping problems, eating disorders, decrease in sex drive, general feelings of lethargy. In terms of emotions, the symptoms can be agitation, crying, feelings of negativity, hopelessness, inadequacy and gloom.

Other respondents also spoke of the 'body-mind axis' but explained their tendency to rely on one explanation rather than another. For example, a middle aged male doctor of Russian origin said that he stressed and usually looked for the emotional dimensions of such a condition:

> Depression is a condition which affects the mood of a person. It can present as a host of physical but mainly emotional problems. The mood is low, hopeless and negative ... a black view of the world ... and the person's feelings are down, perhaps apathetic with little motivation to get out of bed and face the day ... and physical disturbances of eating, sleep, sex drive, energy and tiredness.

This practitioner's emphasis on emotional factors occurred in relation to his description of what he called 'the most obvious consequences' of depression. At this point at least he was not discussing causes.

Of the doctors who said they thought that depression was recognisable as a physical illness, a 42 year old male practitioner said that when he came to think about it, he probably used psychological terminology to explain the condition, yet he saw it as a physical problem with physical symptoms:

> Depression can appear as anything like sleeplessness, loss of appetite, loss of libido, restlessness, irritability and the like ... But it is really a gross anxiety neurosis ... People who are neurotically depressed are extremely high in their defence mechanisms ... The other category is gross psychotic depression.

In answer to the question, who gets depressed, the doctors' views were given in terms of stereotypes or caricatures of vulnerable people. These stereotype pictures were painted without reference to the theories used to explain the nature of depression in general and it seemed likely that these stereotypes had a considerable influence in diagnosis. In this respect MacIntyre and Oldman (1977) have also spoken of general practitioners' reliance on stereotypes, 'the neurotic woman', 'the typical malingerer', 'the trouble maker.' Once established, these caricatures influenced the conduct of consultations with patients and influenced the content and direction of treatment.

In this Sydney sample, the doctors' accounts of the people 'most likely to get depressed,' produced a picture of three vulnerable groups: women, the elderly and the economically disadvantaged, in particular single parents. There were other groups who were referred to, including, as one practitioner put it, 'people from Mediterranean cultures.' But these other groups were discussed in relation to the issue of who was most likely to seek help for depression. For example, the doctor who referred to 'Mediterranean cultures' said, 'My Italian and Greek patients are more emotional and they admit to feelings like depression more readily than European, Asian or Anglo groups. Mediterraneans have a certain mentality that allows them to admit to and seek help with emotional-type disturbances.'

The issue, who seeks help with depression is different from the question, who is most vulnerable to depression. It is in relation to that latter question that references to women, the elderly and economically disadvantaged groups were poignant. One doctor was emphatic, 'More women than men get depressed.' Others were not so emphatic but said they generally assumed that this was the

case. Their views about the high incidence of depression suffered by women seemed to be a mixture of assumptions which they said they had always held, together with impressions which they had confirmed through their practice. Their impressions were not measurements in any strict sense.

In explaining their beliefs that many more women than men were depressed, some relied on what they referred to as common sense assumptions but most gave illustrations from their clinical practice. The common sense view was explained by a practitioner who said 'women have far more to get depressed about than men.' Another male doctor was more specific.

> Without a doubt women present far more often with depressive problems. The social role that women are placed in in this culture, or indeed in most cultures, gives them a raw deal in their lives and it's no wonder they react with some sort of experience of depression. Social conditioning as well as social conditions are different for the two sexes from the word 'go'.

Other practitioners referred to what they saw in their practice, not to social conditions generally. They had observed that far more women than men presented with symptoms of depression and from this they had assumed that the incidence of this condition would be higher among women. None of them had ever discussed with an interviewer and only a few of them with their colleagues why this was the case. An Australian born male doctor aged 65 elaborated his views on the likely differences in the incidence and the nature of depression suffered by women and by men.

> I have a preponderance of women who come to me with their depression. Women are more explicit in their misery. There are differences in presentation as well. Men present with psycho-sexual problems and women more with tiredness, sleeplessness saying things like, 'I can't cope with things,' 'things are getting on top of me.' With men it is loss of sexual energy and impotence or they drink heavily.

Other comments about the different causes and symptoms of depression as presented by men and women will be recorded in the subsequent discussion of answers to my question 'what causes depression?' However, assumptions about who gets depressed almost always implied causes, a point made clear in many practitioners' stories about the vulnerability of elderly people.

Approximately half of the respondents emphasised 'older people suffer more from depression.' Their assumptions about the relationship between age and depression were captured in two comments. The first showed a doctor explaining the relationship in terms only of the elderly person's personal world. In the second a doctor made links between a private world and socio-economic conditions. The first respondent used individual models of explanation of health and vulnerability to illness. The second addressed the link between health, illness and a social context which in his terms was much wider than one person's immediate social contacts. The 'mainly-to-do-with-individuals' view was expressed by a male doctor, aged 65:

> Well the elderly have higher rates of depression. I'm getting on myself and I understand how it's hard not to get down in the dumps about some things, like failing eyesight, mobility problems, not to mention most of your friends and supports dying around you.

In explaining his own and other's vulnerability to depression another doctor included his observations about current social and economic conditions in Australia:

> It is depressing for an elderly doctor like me to see all the aged people with their depression. But with increasing infirmity, physical illness, loneliness and financial problems related to retirement, it isn't surprising that the elderly become depressed. It's hard to retain your bounce when you have difficulty moving around and everything becomes a big effort. Added to all this, you have social messages about your decreasing worth. And economically you are devalued.

The idea that the people most vulnerable to depression would include those who were 'economically devalued,' and disadvantaged as well as devalued, cropped up mostly with reference to single parents. But there was considerable overlap between references to economically disadvantaged groups and comments about 'the elderly': the vulnerable elderly were highly likely to be poor.

Although these inner city areas in which the doctors operated their practises were not affluent, - they included areas of high rent and municipalities with high unemployment, - only a minority of practitioners made specific references to disadvantaged groups such as the long term unemployed and single parents who lived on a low fixed income. These were the doctors who were

making explicit connections between a depressed person's mood and prevailing socio-economic conditions. They saw such people as vulnerable to depression because of the depressing context which seemed to envelop their lives and which they felt powerless to do much about. A woman doctor aged 32 commented, 'I've worked in socio-economically depressed areas and you see more depression there. It can't be much fun having to worry where the money for the next bill will come from. If you had to go cap in hand to FACS[2] for help, I think I'd soon be depressed.'

An elderly, Polish born doctor also emphasised his belief in the link between socio-economic pressures and vulnerability to depression:

> Those people who are economically disadvantaged - on pensions, the unemployed - are likely to suffer depression. Their depression stems from hopeless life circumstances and a hopeless future. I can see how it would be hard to sustain a sunny disposition when you can't make ends meet.

Assumptions about Causes, Interest in Treatment

Questioned specifically about their views on the causes of depression, there were numerous observations which were a repeat of explanations about the vulnerability of women, the elderly who were poor and some other socially disadvantaged groups. Questions about their interest in treating people who were depressed also revealed more observations about causes and produced an evaluation of the inadequacy of medical education and training to prepare general practitioners to deal with such a widespread public health problem. Questions about their knowledge of and interest in this condition were also intended to give respondents an opportunity to elaborate their view of causes and their accounts of what they did by way of treatment.

Answers to the question 'what causes depression?' produced an intricate web of points about vulnerability, life strains and coping patterns. From this web emerged a pattern of comments about 'loss' as a major cause of depression. Some doctors talked about the loss of a loved one, others spoke of the loss of a person's

[2]A reference to the Department of Family & Community Services, - as it then was.

good health, the ending of a significant relationship or the loss of one's country or culture.

References to gender, age and something elusive called 'personality' were not as common as references to 'loss' but somehow seemed to be more specific, as though 'loss' was a second order concept in analysis whereas the importance of age, gender and personality indicators did not require much analysis. But it was not always as simple as that. A woman doctor of 33 said:

> Women's socialisation in this culture and the unsatisfying and unsatisfactory position in which they find themselves makes for depression. This is not always the case. Some women obviously get depressed about their social role. Some accept it. Others work and get satisfaction. So it's not hard and fast. There are other reasons for people getting depressed. For instance those people in bad relationships, have just separated, divorced or suffered a bereavement. Also a lack of money can be a cause of depression. Life's not exactly a ball when you don't know where your next meal is coming from. Work pressures can also cause depression but here its the men who are most affected. Trouble at work can be distressing. Retrenchment and retirement can cause depression ... I am not saying these things always cause depression. It depends on the person's disposition.

Another female doctor, aged 39, trained originally in Hong Kong, commented:

> Life problems like marital discord, bad health, problems with children can cause depression. Women are more prone because of the position, especially housewives, find themselves in. These women are often overworked and have little money. Men usually have work problems which cause depression. It is easier to get depressed if you have no money, can't go out, can't distract yourself.

A Russian born and trained practitioner aged 56 said:

> Unhappy life experiences, crises in life, say losing someone you love, leaving one's country, losing a job, all these things can cause depression. But people are different. One person will be depressed for the same reason that another person will not get depressed. Who is to say? Sometimes when people have too much time to think about problems they get depressed.

Questioned about his comment 'too much time to think about problems,' he said he was thinking of social isolation. He knew of patients who 'have a lousy view of themselves.' This 'lousy view' seemed to be confirmed not by what others said but rather by what they did not say. The socially isolated individual with 'too much time' hardly ever had a conversation with anyone. They had no-one who might even ask them questions, 'unless they make an occasional visit to their doctor.'

Even the handful of practitioners who seemed keen to enquire into the social conditions affecting patients' lives, and in this sample that appeared to be mostly the female doctors, said their knowledge of and interest in a condition like depression had almost nothing to do with their own training. On the contrary their training had left them ill equipped to explain depression let alone treat it. In their medical training, and, if they were overseas trained, in their re-training to requalify in Australia, these respondents recalled that training had emphasised the scientific measures of 'biological depression.' This emphasis has been familiar to critics of a particular scientific view of medicine, Feinstein, for example, wrote:

> A clinician performs an experiment every time he treats a patient. Yet we have never been taught to give our ordinary clinical treatment the scientific respect accorded to a laboratory experiment. We have been taught to call it art and to consign its intellectual aspects to some mystic realm of intuition that was unworthy of scientific attention because it was used for the practical everyday work of clinical care. Clinical judgement depends not on the knowledge of causes, mechanisms or names for disease, but on knowledge of patients. The background of clinical judgement is clinical experience: the things clinicians learnt from sick people. (Feinstein, 1967).

A Chinese doctor echoed Feinstein's criticism. He said that throughout his 'Western-type training,' scant attention had been paid to a holistic model of practice, to explaining a person and their illness by placing both in context:

> Medical training emphasises pathology. It is not interested in how the person lives and thinks. Doctors are supposed to fix up things physically and physiologically. This idea is deficient. I know that as an Asian person, I see the world differently to a westerner. Doctors need to realise that people have different circumstances and beliefs to doctors.

An Australian born and trained doctor said it was the irrelevance rather than the absence of commentary on depression which had left him feeling ill equipped:

> As medical students we learned all about the really gross presentations of depression. I've seen very few of those in my practice. I could probably count on two hands the number of times I've seen a psychotic depression. But I see neurotic depression every day. This is the sort of depression the G.P. sees, yet we learned very little about it in our formal training.

Although medical training may have equipped them only to recognise the 'gross' or 'florid' presentations of depressive behaviour, many said they had developed their own practice wisdom, a combination of theories built from intuition, trial and error. One practitioner explained, 'I have a feeling about a particular case and I know almost instinctively how to deal with it. I've called one common presentation, 'the bored housewife syndrome.'

He went on to explain that he had some techniques to deal with the woman whose 'illness appears to be boredom.' Such a condition, he said, was a reactive depression reflecting that woman's frustration with her role in life.

Another doctor said although his medical training had ignored socio-economic conditions and their effect on health, he could recognise the depression of the unemployed man, the retrenched worker. As a result of working in a neighbourhood where unemployment had persisted for years he considered that he had now developed ways to handle the reactive depression which resulted from such experience:

> Unemployed men seem to go through stages, usually the depression gets worse the longer they're out of work. I might start off with some assurance and helping them sort out their options, but as time goes by and they're still unemployed they might need counselling, even some medication.

The thought that some patients 'might need counselling' had prompted just a few of these practitioners, no more than six in this sample, to develop an interest in and, in a couple of instances, to enrol in short courses in counselling as

a form of treatment. They had done so even though they conceded that this initiative had not been consistent with the scientific bias of their training. A male doctor, in his middle thirties explained, 'I learned counselling skills years ago and I like to use the rational emotive theory and practice methods with most of my depressed patients.'

He did not elaborate on 'rational emotive theory' and when questioned said it was a means of 'focussing on an individual's feelings.' By contrast, two female doctors explained that their grasp of counselling included a concern to enable a depressed person to explore 'life circumstances and social context.' One of them explained:

> When I say I counsel my depressed patients I don't necessarily mean I use some known therapy techniques. What I mean is that I listen to them and help guide them. I discuss options with my patients and help them potentially to help themselves.

The second female doctor said that although she felt competent and confident in counselling her patients, she was a doctor not a counselling specialist:

> I give my depressed patients time, I try to be empathic and I offer alternative strategies. Much of the depression I see is socially and societally based, so I do a bit of what used to be called consciousness raising. Many of these depressed people think they're alone, and it often helps them see things differently when someone can help them see it's not them alone and not their fault.

Among this small number of doctors who said that they had some interest in counselling, only one appeared to be saying that counselling of some kind had become his medical specialism and he was therefore almost grateful to have patients 'with whom I can practice my specialist theories and methods.' This 43 year old male doctor, who also was fascinated by hypnotherapy, explained:

> I use psycho-therapeutic techniques with most of my depressed patients. But sometimes I use even more specialised techniques--like hypnotherapy. I believe in the powers of hypnotherapy for most neurotic-type problems.

This practitioner, in common with others, agreed that his particular interest affected his diagnosis and his motivation to offer treatment. Depending on their level of interest such 'motivation' might prove to be a resource or a constraint for patients. Their level of interest varied. At one end of the spectrum were those few who expressed great interest in the condition including some who had experienced depression themselves and were therefore motivated to help others in a not dissimilar predicament. At the other end were those practitioners who were not very interested in this condition and did not see the treatment of depression as an appropriate, or even a possible use of time in general practice. These two extremes of interest and disinterest could be depicted by the notions of a preference for practice which addressed the intangibles of illness and that which dealt with the tangibles. Among the 'preference for intangibles' group was a Polish trained practitioner who explained:

> In general practice you get all sorts of presentations. I enjoy treating something like depression because I find it a challenge. It's much more of a challenge than some other more simple, straight forward things that a doctor tends to get in general practice, like coughs, colds, sprains and broken bones.

Several practitioners said that their preference for the intangible challenge of a phenomenon like depression occurred because of their own very personal experiences. In consequence they empathised with depressed patients. They prided themselves in offering what one called 'a sympathetic ear, solace and guidance.' In his opinion, these responses comprised the essential and sometimes the only treatment for patients who seemed to be living through some stage of depression.

A British trained doctor said that his own experience of depression as a medical student some twenty years previously, had been a significant influence on his attitude towards and his understanding 'of people in a depressed state.' He elaborated:

> To this day I can still remember how I felt when I failed my final exams. There was a lot of pressure on me to do well but I was lonely, away from home, I had had an unhappy love affair, a really bad student placement experiment. So, when I failed I wasn't really surprised but I suffered for a long time. That did surprise me.

> Because I experienced this depression I now find I can really understand how some of my patients feel. I can still feel it right in the stomach like they can.

Doctors who expressed a clear reference for 'tangible doctoring' included one who said that he and his partnership colleague 'would rather treat a broken ankle than depression.' A similar sentiment was expressed by another doctor, not his immediate colleague, who summarised his views:

> Depression is such a common presentation yet it is a frustrating one to deal with. It is relatively easy to treat the symptoms but one never knows how effective this really is. What are the causes? Often you can't even begin to treat them, even if you knew what they were. Doctoring is much easier when things are clear cut, like fractures and skin problems for example.

Questioned about their referral practices if they saw what they thought was the intangible problem of depression, they said they would usually refer elsewhere 'psychiatric-type problems.' This label, 'psychiatric-type problems', was used by a practitioner who said he was clear in his own mind, 'I do not have much time for neurotic illness.' Others also said they had no interest in a condition like depression because they saw it as falling outside their responsibility to deal with 'the tangible.' For them, depression would be either a 'clinical condition' and would therefore merit referral to a specialist, usually a psychiatrist, or it was diagnosed as 'neurotic,' 'unrealistic reaction', 'life stress situation.'

The diagnosis 'clinical' apparently meant something serious, of a psychological nature, whereas the label 'neurotic' and the other adjectives used to express essentially the same thing, meant that at best a patient should be given a short consultation including perhaps some medication. The appropriate short consultation, in one doctor's words, would aim to 'buck up the patient, help them see that things could be worse and that they would improve.'

The doctors who emphasised their interest in tangible doctoring but expressed little interest in depression saw the condition as an either/or phenomenon. They had ready made answers to it: referral to a specialist, or quick advice and medication dispensed by them. They did not refer to non-medical

sources of help. 'Non-medical' here refers to professionals other than psychiatrists: to social workers, psychologists and counsellors.

This reluctance to refer to non-medical practitioners was at first sight surprising given these doctors' reliance on the distinction between psychotic (which they referred to as clinical) and neurotic depression. One was seen as a medical condition which required specialist medical help. The other was seen as a non-medical condition which they argued was best treated 'non-medically.' However, even this group of doctors were not alone in their apparently trained and conditioned reluctance to refer to potential non-medical sources of help.

Financial and Other Constraints of General Practice

Whatever their views about the causes of depression and the people likely to be depressed, whatever theories they used to explain their treatment of such patients, were held and practised under common organisational constraints. Although such constraints are the last dimension to be discussed in this account of the context of general practice, they were so influential as to virtually transcend the other considerations which the doctors said affected their attitude to depressed people. Even the most motivated and well prepared practitioner would find it difficult to diagnose and treat people who were depressed if the conditions of his work were experienced as more hindrance than help.

The constraints which proved to be 'more hindrance than help,' were illustrated in two comments, 'time is money' and 'there's far too much government interference.' From some doctors' perspective, those comments provided a stereotype picture of the 'public' (Medicare) and 'private' (fee for service) system by which patients paid and doctors were reimbursed for their work. In theory, and according to the principles underlying citizens' entitlement to at least 85% of the cost of general practitioners' time, - under the Medicare scheme of universal health insurance, -practitioners could and should offer a service to all patients, but the principle of service according to medical need clashed with many doctors' idea that doctoring was 'a small business.'

Even if they subscribed to the small business idea, that posed another problem. Some emphasised that they were not 'free' to develop that small business because they were depending on government subsidies and in consequence 'government interference.' One doctor expressed this point, 'The government runs Medicare and keeps an eye on us all, making sure we play by the rules of the system not outside them.' Even those who said they preferred to think of general practice as a community resource, admitted they also had to pay a lot of attention to the business side of their activities. These comments were made by women doctors who worked for others on a part time basis, by doctors in partnership and by sole practitioners.

The business dimension of doctoring was a constraint when it came to pondering what to do in response to a condition such as depression. Fee for service meant a pressure to provide only short consultations which were cost effective. Even if there was not a crowded waiting room of other patients, this fee for service systems precluded spending time unravelling the details of a patient's story. One male practitioner explained the 'time is money' theme: 'Look, you can't spend too much time on things. It is unfortunate, but that's it, it costs too much.'

Another practitioner, who had been in general practice for forty years, expressed the same sentiment. 'The doctor can't afford to give more than about six to eight minutes to the patient. The G.P. cannot afford to spend time with people under the present set of arrangements. You are aware of losing money if you do.'

Another male practitioner, aged 42, expressed his professional dissatisfaction with such conditions of practice but said he had learned to be pragmatic. 'I hate it but it's a system that is imposed upon us. I'd like to spend more time with some patients but it doesn't pay. An eight to ten minute session is all we can give to most people.'

The doctor, quoted above, who at age 66 had spent forty years in general practice, summarised that he saw as the current tensions in his work, 'tensions' which he said were, ironically, 'depressing.' 'Health care arrangements and

rebates as they stand at the moment make it more attractive for me to see more patients for shorter consultations. It is a reality and a necessity.'

All the respondents recognised the time and financial constraints of practice but those who said they approved of the idea that doctoring was a business, appeared to be describing themselves as preoccupied with diagnosing and treating in the shortest possible time. Questioned about this issue, one of this group said 'Yes' the diagnosis and treatment of depression called for time consuming procedures, listening, gathering information, feeding it back to a patient, 'and perhaps even counselling them.' But in his view such time was not available.

By contrast, the practitioners who were critical of the 'time is money' principle, said that they usually gave short consultations but where they recognised symptoms of depression, they felt they needed and were prepared to find more time to question a patient who presented with the symptoms of this kind of illness. They said that they offered longer consultations and either billed the patient for them, or charged a standard consultation fee irrespective of the time spent. A female doctor who worked part time explained:

> I don't have the heart to not give some of these people some time. They're absolutely desperate, they need someone they can pour out to and I feel I should do that much for them. However, I am aware of the time problem and sometimes I get people who are very anxious and depressed to come back to me the following week, if I think they need more time.

The practitioners referred to earlier who had some interest in counselling, in one example hypnotherapy, expressed their dismay with what one of them called 'this business of a quick turnover of patients.' In order to give counselling, let alone make plans for hypnotherapy, they disregarded the common expectation of short consultations. In this respect they were deviants in a medical culture which, whether reluctantly or with approval, felt bound to weigh the financial costs of seeing patients and make assessments of the cost effectiveness of any suggestions about treatment.

The observation that government interference was an ever present constraint on practice referred to various aspects of medical administration. One practitioner complained that Medicare arrangements meant his filling in forms 'constantly.' This requirement, 'a demand really,' he said, 'will increase if medicine becomes really socialised.' Another example of the 'too much interference' theme was expressed by a practitioner who prefaced his remarks with the comment, 'I don't want to seem paranoid but, ... the Medicare people would want to investigate my practice pretty smartly if I started making a practice of seeing too many people for long consultations.'

An unusual exception to this pattern of short term consultations costing the standard fee was given by a practitioner, of South American origin, who had just opened his practice under conditions which he said might be considered ideal for patients who suffered from depression. 'I am motivated at the moment by having perhaps too much time.' He said he currently had too few patients and therefore, 'I see most of my depressed patients for long consultations. I can do this because I am not busy. Perhaps when I get busier I'll change my mind and it won't be so easy.'

The definition of a manageable caseload for doctors would depend on whether the criteria to measure 'manageable' depended on business criteria or on considerations about optimum conditions for patients' treatment. In this respect a pessimistic view of the constraints affecting the operation of their surgeries was given by several doctors. They said they knew that these conditions, the crowded waiting room, the ritual of waiting and being seen only briefly, limited their freedom to practise and the patients' sense of freedom to be able to explain their story. Perhaps the best confirmation of the doctors' admission about the constraints on their practice, - the organisational constraints rather than the constraints of interest and knowledge -, should come from some patients. Several of the 80 patient interviewees who had consulted a general practitioner had found the experience of waiting and being seen briefly as demoralising.

One said that being seen so briefly after such a long wait, 'I was there for almost an hour,' was not only frustrating, 'it was offensive.'

Despite their strong feelings about such matters no patients had ever complained. In common with the findings of a study of women's consultations with their doctors (Roberts, 1985), these patients had accepted their frustration and assumed, somewhat fatalistically, that each doctor was too busy to alter the conditions of his practice. The patient may have been depressed. A key person who might have helped was seen as working under depressing conditions. On the similar patterns observed in her work, Roberts concluded:

> All this adds up to a situation where women, although recognising just how pushed they are themselves for time, - are more apt to recognise how busy the doctor is than fully acknowledge how busy they are themselves, and what sort of effect this might be having on their health. (Roberts, 1985, p. 24).

Many of the doctor respondents said they were aware of these unsatisfactory aspects of the organisation of their practices, in particular the ways they were paid and the consultation procedures which they followed in consequence. But they felt unable to change them. In some ways they felt as immobilised and as stuck as some of the respondents who were depressed. The constraints on practice were also having a negative effect on the practitioners. One explained:

> It's really a terrible game both doctors and patients have to play. I don't like the pressure on me any more than the patient likes being treated in the shortest possible time. It creates a tension we could both do without. But until someone invents a new charade, we all have to play this unsatisfactory one.

CHAPTER 11

WILLINGNESS AND RELUCTANCE TO SEEK MEDICAL HELP

In terms of the reported steps in seeking help for their experience of depression, the respondents fell into two groups: those who consulted their general practitioners and those who did not. However, this distinction does not imply the existence of people who were necessarily different in other respects. It merely reflects those who reported consultations with a G.P. and those who, at least with regard to the experience of depression had not made such consultations. I have called those who attended their doctor's surgery for help with their depression, willing to seek medical help, and those who reported that they did not seek such help, reluctant to seek medical help. Forty three respondents, 11 males and 32 females sought such help. Thirty six respondents, 13 males and 24 females did not. (Table 11.1).

Table 11.1: Who sought medical help?

Action Taken	Males	Females	Total
Respondents who sought medical help	11	32	43
Respondents who did not seek medical help	13	24	37
TOTAL	24	56	80

It is indisputable that some people sought medical help for their depression, but the meaning of the notion 'sought medical help' is not immediately obvious. Paradoxically, one way to unravel such meaning is to examine why some people did not visit a doctor.

In order to examine the apparent differences between those who did and those who did not seek help from a doctor, I shall consider first the explanations for the reluctance to seek help. Secondly, the motivations of those who consulted the general practitioner will be examined.

Reluctance to Seek Medical Help

'I thought I'd just ride through the storm...'

Even with such common conditions as toothache, people may ignore the early signs in the hope that it is nothing serious and that a visit to the dentist can be avoided. So it is with depression. The 'ride-through-the-storm' comment, made by a 52-year old married woman, who worked part-time in a clerical job, was typical of those respondents who saw 'no point' in consulting a doctor and preferred to 'sit it out and see what happened'.

However, when pressed on the issue of what actions they had taken in response to being and feeling depressed, four main reasons for not seeking medical help emerged. Sitting it out and seeing what happened indicated that they thought they could 'contain' their depression. Such containment was not necessarily something which they did by themselves. They did have other means of help. The four reasons given for not seeking medical help are as follows:

(i) going to the doctor means the matter is taken out of their control
(ii) the belief that there is a strong stigma associated with admitting to being depressed
(iii) perceived usefulness of the doctor
(iv) past experiences with doctors

There will be no attempt to pigeon-hole people in particular response categories as most people had more than one reason for not seeking medical help. In this respect, the four categories are permeable: some respondents gave single explanations, others gave combinations of reasons.

(i) Going to the doctor means losing control

The process of minimising a problem and 'accommodating' the difficult circumstances shows people trying to convince themselves that their experiences are normal. Such processes, often described by researchers as a process of 'normalisation' have been regarded as a common response to 'mental' or 'emotional'

experiences (Yarrow et al 1955; Mills, 1962; Mechanic, 1978; Hammer, 1968). The tendency to avoid taking action by minimising and accommodating a sense of feeling low or unwell shows something of the impaired social functioning which has come to characterise the behaviour of people who are depressed. Many of the respondents spoke of their 'adjusting' to their sense of 'operating below par', at home and elsewhere. But it was not only respondents who had curtailed their social roles and activities as a result of feeling depressed. Other family members were described as making adjustments to the impaired social functioning of the depressed person.

In an effort to not lose control of the situation by having to seek formal medical help, some respondents and significant others 'stretched' their views of 'normality'. One respondent, a 26 year old professional man, a teacher, epitomised this response of adjusting and accommodating in an effort to maintain control:

> I didn't see much point in going to the doctor. I'm the sort of person who likes to feel in control. Even though I knew I was out of control, if you like, and not functioning at my peak, I didn't want to lose control, even further. Going to the doctor would confirm what I knew and I would lose even more control.

Respondents' explanations of operating at a low ebb included comments about the fear that they were losing control of their lives. Yet they did not seek help. They thought that their fear of losing control would be compounded by being told they were about to have a 'nervous breakdown'. One respondent, a divorced 40-year old woman, living on her limited pension income with three adolescent children explained her fears:

> I thought I was losing my mind. Things looked bleak and I had all these things go wrong with my body. I was scared so I tried to be as normal as usual. Of course, my kids and friends picked up I was below par but I didn't want to go and be told I was going to have a nervous breakdown. I guess people just started to expect less of me and then, one day, it all blew over and I felt like me again.

For this woman, and others like her, the response to a feeling of being impaired socially, was to modify expectations of themselves and keep control over their lives as much as possible. Going to the doctor was seen as relinquishing that

control. Seeking medical advice implied her thoughts and feelings might be taken from her. Her control, although diminishing, might be replaced completely by a professional giving attention to her problems. That professional was almost always a doctor. He or she was perceived as an authority figure who could make a judgement and possibly influence the direction of their lives. Paradoxically, some respondents wanted a change of direction but did not want to risk any dependence on outsiders to achieve it.

Helen Roberts in her study of women and their doctors found that some women's anxiety, nervousness and even fear of putting their plight in the hands of the doctor led them to delay consulting that professional. Alternatively, they sent a proxy, in most cases, their husband (Roberts, 1985). A respondent in the present study, a 42-year old migrant woman said:

> I probably know as much about depression as the doctor - why should he sit in judgement of me? It might be difficult at first, but I can master the feelings of depression I have, I do not need someone to take them over and maybe patronise me as well.

Another woman, a 28-year old with a small baby was even more explicit:

> I thought about going to the doctor but I put it out of my mind. To tell you the truth, I was worried he'd see me as neurotic or something and give me tablets...that's about the last thing I want...I watched my mother destroyed by her pill-popping.. She started off on 'nerve tablets' and then ended up not being able to give them up. I decided that wasn't for me.

What this group of respondents had in common, whatever differences existed between them, was their reluctance to lose even more control over their lives. For them, going to seek medical help was confirmation that they were not coping, a fact that many of them said they were attempting to minimise. The next group of respondents went further by sharing their belief that any attempt to seek medical help would be stigmatising.

(ii) The belief that they will be stigmatised

Stigma refers either to an attribute which is deeply discrediting, in terms of the view people have of themselves, or it refers to undesirable characteristics attributed to them by others (Goffman, 1963). In this latter respect, stigma is a label imposed by others. It singles out certain attributes, evaluates them as unworthy and devalues the person who possesses them.

Stigmatised illness can be thought of as a continuum from the barely stigmatised to the very stigmatised. Similarly, the various stages of losing control of social functioning - in these key areas of work, relationships and social conditions could lead to feelings of increasing stigmatisation. Once having lost control, the next step was to admit to dependence on others. Such dependence could range from the least stigmatising experience of consulting a general practitioner to the apparently more threatening experience of being referred to a psychiatrist. The latter process carries with it the connotation of possible admission to a psychiatric hospital.

A New England study showed that a person with a behaviour or emotional problem is more stigmatised if he or she seeks help of any sort than if they do not (Phillips, 1968). Phillips studied help-seeking from four sources: the clergyman, the doctor, the psychiatrist and the mental hospital. While any help-seeking was stigmatised, the highest degree of rejection was accorded to those consulting the mental hospital. Those consulting the psychiatrist were next in order of rejection and stigma. The help-seeker was being defined as someone who has a problem, who was therefore compared unfavourably with those who are seen not to have problems (Phillips 1968).

The ability to 'manage one's own problems' and 'stand on one's own feet' is much valued in Australian society where independence and being seen to be strong, healthy and successful is central to claims about what is normal. Someone who seeks help is likely to be defined as unable to handle problems and therefore, not conforming to a norm.

The fear of being seen to be 'not coping' and 'not managing' or, worse still, being labelled as having a 'mental problem' kept some people away from the doctor's surgery. The belief that they would be stigmatised by admitting to a 'weakness' explained such respondents' reluctance to seek medical help. A 36 year old woman, Emily who had lived in a long-standing de facto relationship and was pregnant with her first child said:

> It's bad enough feeling lousy, but it would be the pits being seen as a loony...that's the way some people see it, maybe even the doctor...it's best to keep away and not blow your trumpet about it.

Her reference to 'being seen as a loony' was a judgement of how others would see her. In subsequent discussion she conceded that no-one had hinted that she would be regarded as ill if she sought help. The over-riding fear lay within herself. It was not something which others had said explicitly.

Another woman, single and aged 26 was adamant that any formal admission of her experience of depression would lead to being stigmatised:

> You know something's wrong and you can almost name it - well, I can. But that doesn't mean you want to go to the doctor and hear it said out loud. Not that I think it's a mental problem or anything, but the doctor and other people might think I was losing my marbles - it's not good to have that on your record!

The general practitioners said they understood the point that this woman was making, at least they understood in general terms, but not with reference to this specific woman. Some general practitioners said that while they did not see depression as a stigma, they believed the 'general public' still had difficulty in seeing any mental or emotional problems in stigma-free terms. As one doctor, a 42 year old male put it:

> Once something captures the public's imagination, no amount of factual input can shift attitudes quickly. Some lay people still lump all emotional and mental illness experience into the loony bin category.

The fear of being stigmatised has been confirmed by researchers and doctors. Those respondents who expressed this feeling have been confirmed in their fear by at least some experiences of rejection by others and in some instances of rejection of themselves. For the next group of respondents, their reluctance to seek medical help had less to do with feelings about themselves, and everything to do with their perception of the doctor.

(iii) Perceived usefulness of the doctor

If someone decides to seek expert advice, the selection of the appropriate person will depend on how a problem is defined. A person feeling pain in the jaw might put it down to trouble with teeth and decide to visit a dentist. Someone else might suspect sinus trouble and consult a general practitioner. A person experiencing feelings of depression may have no clear idea as to the likely source of help. People consult prospective helpers if such significant others are perceived as likely to be useful.

If a problem is defined as 'emotional' or 'environmental', the person may not perceive the doctor as the most appropriate professional to consult. On the other hand, if someone cannot recall non-medical sources of help and if they have also found a doctor helpful regarding emotional matters, that person might seek medical help.

A 48 year old Italian migrant, a resident of Australia for 25 years, had lost his wife two years earlier. He made a long statement about what he found useful when he was depressed. Most of this related to non-medical alternatives. Part of his statement included an explanation of his non-use of a doctor, 'some others tell me to go to the doctor. What can he do? He gives me tablets...what for? I don't have a pain in my body.'

This judgement was repeated by other respondents who experienced depression as an emotional state rather than a physical illness. They were unwilling to consult the doctor because, in assessing their experience of depression, they did not perceive him or her as being useful to them. A single woman of 28 who worked as a theatre sister said:

> What good would going to the doctor be? There's no magic wand - just tablets and perhaps a pep talk. I know what's wrong with me - I know why I have certain bodily symptoms. I've also got a fair idea why I get depressed, so no medical intervention would be of help to me.

Another respondent, a 38 year old married woman with two children, spoke of her previous decision to consult a doctor. Her relationship with her husband had a tempestuous history. Regarding this stormy relationship, eight years ago she turned to consult the doctor for her depression. She had made that decision because she had perceived the doctor as being the most appropriate and useful professional helper. However, in her words, he was unable to solve either her depression or her marital difficulties. He prescribed some medication. As a consequence, 'I walked around in a foggy state until I woke up to myself and threw the tablets out'.

She said this experience had changed her mind about her doctor's usefulness. When she became depressed on this most recent occasion (the subject of the current interview), she recalled that her doctor had been of little use and she therefore did not consult him now. She turned instead to a counsellor who had been recommended by a friend:

> Since I didn't find the doctor helpful last time, why repeat the experience? I really resented being given a lecture, patted on the head and sent out with a prescription to make me 'feel better'. What I needed was someone I could talk to, someone who would listen to me.

This notion of the perceived usefulness of the doctor was closely linked with the recall of past experiences with doctors. Recall of past experiences influenced whether a doctor would be perceived as likely to be the person with whom to discuss their current sense of losing control and their sense of impairment.

(iv) Past experiences with doctors

When people feel that their general practitioner is too busy or seems uninterested in their problems, they are less likely to consult him or her (Cartwright et al 1973). So too with some of the respondents experiencing depression: some discouraging past experiences lessened the likelihood of future consultation.

By the time an adult contemplates medical help, he or she is likely to have had some contact with the medical profession, whether in an ongoing relationship with a general practitioner, or more infrequent contacts with a range of different medical practitioners. In the words of some respondents, even the decision to seek non-medical help was influenced by previous experiences with doctors. Each individual's interpretation of their previous 'treatment' affected their subsequent decisions. If the past decision was unpleasant or disconcerting, as when a doctor was perceived as impatient, indifferent or lacking in understanding, the person would be reluctant to put him or herself in the same position again. Conversely, satisfactory past treatment will incline them to repeat the experience.

If the doctor was previously experienced as too busy, uncaring and uninterested in the person's problem, then future willingness to return and consult on similar matters would be unlikely. Some respondents complained that in their previous brief consultations with the general practitioner, they were unable to say much about how it really felt to live with 'this awful feeling'. They had not perceived the consultation as allowing them the space to talk about the quality of their lives. There was not the time or attention given to them to openly discuss conditions at home, work or the state of their relationships, with a partner, family members and friends. When the person in the role of the patient recognised that the doctor was concerned only with their physical condition and not their social circumstances or their feelings, then he or she was reluctant to seek medical help. It was as though the doctors who had been consulted in the past were remembered, in part, because they seemed to be insensitive to the context of the patient's life, a point similar to that made by Kosa:

> 'The morbid episodes of life - symptoms, illnesses, disabilities as well as their attempted cures - cannot be regarded as purely physiological processes. Their full understanding requires a systematic consideration of the social and psychological context in which the episodes occur'. (Kosa, 1966)

An example of a respondent who, based on her past experiences with doctors, was unwilling to consult one for her feelings of depression was a 40 year old woman, married with four children. She said that her experience with doctors had been 'atrocious'. She acknowledged that sometimes they could be useful, but not for 'emotional things':

> The doctors I've come across have never taken me seriously. Even my general practitioner was a smug sort of bloke always hinting that I'm neurotic and calling me 'girlie'. Well, I'm hardly going to reveal my soul to someone like that. Maybe it's just that none of them have had to struggle and be put down and then feel low. I mean I've had to put up with so much over the years - a husband who bashed me and the kids, a divorce, living alone and trying to raise the kids, trouble with the kids, my Mum and Dad dying,having no-where to live for a while and then getting married again and having money hassles. Who wouldn't feel low?

The relationship of stressful life events, poor current conditions of living and impaired social functioning became apparent in a research interview which lasted over two hours. However, if a doctor has limited time and gives only short consultations, the chances of identifying problems and making the links between the patient's social context and their sense of impairment will be difficult. Time element apart, the general practitioner also needs to possess a social-emotional inclination to fully understand and treat a patient's depression (Stimson, 1976, Bywaters, 1986). I have described this attitude elsewhere as a 'social health perspective' on patient's problems, including depression (Mullaly, 1988). Without the opportunity, in association with the doctor, to explore and be at ease in so doing, the depressed person thinks the doctor is uninterested and unhelpful. If the doctor does not pose questions which demonstrate his awareness of the effects of social and economic conditions on health, the patient is unlikely to discuss their feelings of impairment and the consequences. Key issues for the patient, such as performance at work, in relationships and with regard to social conditions, seem unlikely to be on a doctor's agenda.

Willingness to Seek Medical Help

Once the decision has been made to seek help, the choice of helper is influenced by a number of considerations. Sometimes there are positive reasons for choosing a particular helper. On other occasions, the decision may be made by default. For example, if the depressed person is unaware that other professional helpers offer services, the doctor becomes the logical source to consult. In a more positive vein, if the person has had previous positive experiences with doctors, then a willingness to return and consult might be almost automatic.

From the interviews with respondents who said they were willing to seek medical help, four explanations emerged:

(i) past experiences with doctors
(ii) perceived usefulness of doctors
(iii) accessibility
(iv) no other means of support

(i) Past experience with doctors

Both the respondents who were reluctant and those who were willing to seek medical help mentioned previous experience as having been either discouraging or encouraging. If the person has had a positive past experience with a doctor regarding consideration of an emotional problem such as depression, they will feel inclined to return to see the same doctor. A 28 year old woman with a six-year old son emphasised:

> I didn't know who to turn to - you know it's hard to talk about how awful you feel. My doctor has always been really good - kind and he listens - I've told my doctor more about myself than anyone else. I have a really good relationship with him, so that's why I went back to him on this occasion.

For this young woman, the doctor had achieved the status of a taken-for-granted resource. Others spoke of having a 'good relationship' with and 'trusting' their doctor. This was based on having been treated well on previous occasions

and receiving treatment that was recalled as having been effective. A 46 year old single man had previously experienced help and support from his doctor on emotional matters. For him, the doctor was the most logical helping professional to consult:

> The doctor helped me with my other problems before, so when I was feeling out of sorts, I went back to him. He gave me some sleeping pills because I couldn't get to sleep and we talked about my problems of not being able to get a woman, and he sort of cheered me up and told me to take it a little at a time - to go to the club and dances and not get worried if it doesn't happen. After we talked I felt better and knew I had to go out more and not keep myself to myself.

Past experiences with doctors which proved positive, strongly influenced these respondents' present willingness to seek medical help. Some of these respondents who spoke of their past positive experiences, also either explicitly mentioned what they perceived to be the doctor's inherent usefulness. Other respondents described this perceived usefulness as being based either on past experience, or on their current perception of the doctor's role.

(ii) Perceived usefulness of doctors

This explanation of willingness to consult a doctor is also linked to the contrasting point about reluctance to consult. Respondents who spoke about the usefulness of consulting their doctors had positive past experiences. They had been helped on previous occasions and they believed they would be helped again. Alternatively, they held a belief that the doctor would be useful.

Those respondents who indicated that they had never previously sought medical help for emotional problems said that on this occasion, when they were depressed, they decided to consult a doctor about feeling emotionally low, because previous consultations about physical problems had proved helpful.

Previous medical help had proved useful for an emotional problem in the case of a 36 year old widow. She was childless and had always worked full-time. Having experienced a previous bout of depression following her husband's death, and found the experience useful, she consulted her doctor again:

> I knew I could count on my doctor. He was so helpful before when I was depressed. After Rod died, I knew exactly what to do. I couldn't really speak to my mother about it - she's too neurotic - and I really didn't want to burden my friends. But I knew my doctor would help me pull through.

Another respondent believed the doctor might be useful, without basing this judgement on any precedent. Rhiannon, a 24 year old woman who had recently been rejected by her boyfriend said:

> I've never seen a doctor before for this sort of problem, but I get on well with my G.P. so I thought he could help me. I can talk to him easily and he has a really laid-back manner so I don't feel uncomfortable. Because he's been so good with physical things, I thought he would be able to handle emotions.

This young woman's past experience of feeling comfortable in relating problems to the doctor also made her willing to consult him on a subsequent occasion and on a very different matter.

The disappointment of positive perceptions and expectations, was also expressed. Some respondents felt 'let down' by the doctor. A small number of respondents described how their positive perceptions of their doctors had influenced their decision to seek medical help. Subsequently, they felt what one respondent called 'shortchanged' by the experience and thought the doctor had not been as useful as they had imagined. Typical of the dilemma which this experience created was Chris, a 56 year old divorced man:

> I was desperately depressed so I went to my doctor thinking he could help me. I didn't find him helpful. He offered me medication which I refused. I'm not one of those people who has to come out of the surgery with a piece of paper. If I went on medication, I'd be out of control and I don't like that. I'd rather be in control and depressed. I know that sounds like a contradiction but that's how it is...the doctor was singularly unhelpful...I expected him to at least listen, but there was no pretence of that, just a quick consultation and a scribbled script.

These respondents who had been willing to consult the doctor, but whose most recent experience had left them disappointed may, in future, be less inclined to repeat the experience. When their optimistic expectations were not fulfilled,

they felt cheated. A 43 year old married woman who worked as a part-time primary school teacher presented this point of view:

> I assumed the doctor would be able to help me. I held that view because I'd gone to him before with some personal hassles and he'd taken time to listen and talk things out with me...if something works, you tend to try it again. But I felt really let down this time...cheated in fact. Rather than offer me time, advice and some consultation, I got the short shrift...maybe he can't handle people crying on him, I got the definite message that he was uninterested in dealing with my depression.

This ability to 'handle people crying on him' appears to be an indispensable trait in doctors and others who are asked to respond to people seeking help for feelings and experiences of depression. At least, this is the verdict of this respondent and others.

(iii) Accessibility

The choice of seeking medical help is influenced by a practical consideration which at first sight does not appear to be associated with respondents' definition of their problems. The accessibility of the helper influences pathways to particular forms of help. For example, general practitioners are perceived as accessible because they are known: people turn to them with a great variety of difficulties, including relationship problems, emotional concerns, financial and housing issues (Shepherd et al, 1966; Cartwright et al 1973; Roberts, 1985; Mullaly, 1988).

Other possible, more relevant professionals are neither so well known, nor so easily located. People only possess hazy notions of the roles and competence of social workers, psychologists and marriage guidance counsellors; and potential referral agents, such as doctors, do not have a habit of making referrals outside medical networks (Huntington, 1981; Mullaly, 1988). When the doctors do make referrals to non-medical professionals, they do so cautiously. One doctor in this study said he was willing to refer to non-medical people 'carefully', that is, he would do so if he knew the prospective helper and if he had reason to be confident in that person.

Those depressed people who are able to find a social worker or psychologist or counsellor, perhaps because of previous contact or persistence in trying to discover their existence and unearth the location of such other professionals, may turn to that helper with the same problem that someone else would take to a doctor. Respondents who said they were unaware of the free services provided by alternative non-medical helpers in community-based agencies, such as community health centres, included Glenys, a 36 year old married woman with one child. In the stress and confusion of a failing marriage, she said she was unsure about other services but certain about where to find a doctor:

> I'd been depressed for some time and Steve, my husband, was part of it all. My friends reckoned he was the cause of it... Anyway, I wasn't sure I should talk to my doctor about how I felt - he's Steve's doctor too. But I couldn't hold it in and I was so down, not knowing where to turn, so I decided to go and see the doctor...as it happened, he referred me to see a social worker at the community health centre...which was good, because I never knew these people and places existed.

Neil, a 43 year old married man who worked as a travelling salesman, spoke in a similar vein. He had a history of depression and had also received in-patient psychiatric treatment. Although he knew of the existence of other medical and non-medical professionals, if seemed logical to consult the general practitioner when a depressive episode recurred:

> When I get depressed, it's hard to think clearly - to think at all. So the most logical thing to do is to go and see the doctor and sort it out or get referred. The doctor is the first stop - just like priests were once when a person was troubled. Perhaps neither are qualified to handle the things that come their way!... But people target them, especially the doctor these days, because you know where he is and you know the procedures - there's a certain sense of security and familiarity, so it's comforting when you're down.

Glenys and Neil's recall that the doctor was the obvious person to consult confirms my own observations and those of other researchers (Stimson, 1976; McCaughey et al, 1977; Huntington, 1981), that many people still regard the

general practitioner as the port of first call, the helper who is a key person because he is known and therefore accessible, even if his time is limited.

(iv) Where there are no other means of support

This explanation for willingness to consult a doctor is intertwined with the previous three accounts. For some people, the doctor was their only means of support, even though that 'support' might mean a ten minute exchange once a week. This researcher did not argue with the respondents' perception of their predicament. Some of them were in a relationship about which they spoke reasonably positively, yet at times they needed to express feelings to and gain support from someone other than their partners. Other respondents perceived themselves as having no viable other alternative, that is, they did not have an intimate relationship with anyone whom they could trust with their innermost feelings. A 41 year old married woman who was childless and resigned to her disappointment over this issue, was also experiencing relationship difficulties. She explained:

> I'm the sort of person who keeps my own counsel. I suppose I could tell people but I don't have that sort of relationship with anyone really. So I went to see my doctor - I mean I've spoken to him a lot over the years and I knew he would understand and help me.

Some of these respondents disclosed their comfort with using the doctor as a source of support, as opposed to the more threatening prospect of unburdening to someone emotionally closer, who might 'judge' them. Mick, a 42 year old war veteran said:

> I could tell my wife about all this but I can't expect her to really understand...she has to live with me and I can be difficult...I feel better about unloading to someone other than someone who knows me real well...I feel safer.

This feeling of safeness was echoed by Sheree, a 26 year old woman, living in a same sex relationship. She spoke of her fear that others closer to her would sit in judgement of her if she revealed the full range of her powerful emotions to

them. For the particular support she felt she needed when depressed, she preferred the relative anonymity of consulting the doctor:

> I don't want to reveal everything to Jan or any other friends. I mean I tell them some things but if it's too heavy, like this depression I've had - well, its easier to tell someone who's really a stranger to you...he won't judge me as harshly - at least that's what I think...I don't want to give away too much to people I know well - it could be embarrassing later on for all of us.

For a few respondents, there was literally no-one whom they perceived as supportive and so they turned to the doctor as their only means of support. For others, like Sheree, and Mick the doctor provided a confidential and accessible means of support at certain times in their lives. In some ways, Sheree and Mick had no other alternative. They felt so strongly about not surrendering emotional information about themselves, for fear of rendering themselves too vulnerable, that they sought help from a professional third party with a reputation for treating matters in confidence. In this sort of case, the depressed person would perceive the doctor as their only means of support. Only their doctors were perceived as likely to provide a guarantee of confidentiality and the security of not having the information used against them at a later date.

Before summing up, and in preparation for consideration of the nature of non-medical treatment it could be worthwhile to briefly examine how many respondents found medical help useful and why. Conversely, it is interesting to see how many who sought medical help did not find it useful or were ambivalent about such help. The reasons for their views might shed light on what these respondents expected and why such medical help fell short of their expectations. This has implications for non-medical treatment alternatives.

Table 11.2: Perceived usefulness of medical help

Respondents' Perceptions	Males	Females	Total
Respondents who found medical help useful	4	10	14
Respondents who did not find medical help useful	4	13	17
Respondents who were ambivalent about medical help sought	3	9	12
TOTAL	11	32	43

Those respondents who said they found consultations with their general practitioners helpful spoke principally about their expectations being met by the doctor, either in practical or emotional terms. That is to say, the doctor had prescribed medication which helped to alleviate some of their symptoms, or he or she was perceived as listening sympathetically to the problems presented by the respondents. Some respondents wanted and needed to leave the surgery with a prescription, for example, to help them sleep or to alleviate anxiety which they found impossible to deal with in any other way. Others were clearly satisfied with a 'sympathetic ear' and their feeling that the doctor could be trusted with intimate thoughts and feelings.

Typical of those respondents who said they found the visit to the doctor helpful was Elaine 53, who said:

> I hadn't been able to sleep properly for weeks so I went to the doctor hoping he'd give me sleeping pills, which I'd had before and found helpful. We talked about things and he wrote out a script.

In her case, she sought a practical measure and her visit was rewarded when the doctor met her expectation. Another female respondent, Trish 36, went to the doctor, with whom she felt she had good rapport and a trusting relationship. She already expected to be 'heard out about my problems' and given some support and guidance. She was not disappointed:

> My doctor and I have a good relationship, I've been going to him for yonks. I knew he would listen to me and I could trust him with my deep and dark secrets! I just needed a sympathetic ear to listen to my woes, some support and perhaps a little guidance. You know how it is, it's often easier to see things from the other side, I can't see anything when I'm down.

Another respondent, a single man aged 46, said he expected the doctor to 'understand and help me with my problems'. His expectation was also met. David said he had an impotence problem, which he believed stemmed from his depression. He went to the doctor:

> To talk to him about what I could do, how to overcome this handicap. He talked to me for a long time, was real good, you know, serious about this problem of mine. Then he gave me some tablets to help relax me, and he also referred me to a special sex clinic at the University.

By contrast, the respondents who perceived their encounter with a doctor as unhelpful had been disappointed in their expectation of what the doctor should do. For these respondents, the issue concerned the doctor not giving them the sort of treatment which they expected. There were those respondents who were disappointed that the doctor had not offered a prescription, and those who were appalled that he had. In both cases, these respondents assessed the doctor's treatment as not helpful. The expectation that the doctor would play a father confessor role was also evident. Those respondents who said they had gone in the hope that he or she would provide support and guidance, were disappointed when they felt they left 'empty handed' or 'no more supported now than I was when I went in'.

Eileen, 38, had attended the doctor's surgery in the hope that she be given 'tangible, practical help', that is, tablets. But, her doctor was not the pill-prescribing type. She said she was angry:

> I thought he would just prescribe some tranquillisers or at least sleeping tablets, but I bargained wrong - He was vehemently opposed to prescriptions and wanted to send me to a counsellor, which I didn't want.

On the other hand there were those respondents who expected a counselling session, only to be fobbed off with perhaps a 'pep talk' or a 'lecture about pulling oneself up by the bootstraps'. For them, the experience had been disappointing. Typical of this group was Karen 38, who said she had gone to the doctor for support and some basic counselling about ways 'I might re-order my life'. She recalled that what she received was the 'short shrift' and a prescription. She said:

> I didn't know where to go, but the logical thing to do was to go to the doctor. I thought he would listen to me and give me some moral support and suggest some alternatives - like what I might do to help myself, what I got was about five minutes and I was quickly shown the door with a piece of paper handed to me. I hate taking tablets so I didn't bother going to the chemist with the script.

In all these cases, the respondents had expected one form of treatment and been surprised and disappointed when they received another sort.

Finally, there was a group of respondents who sought assistance from a general practitioner, clearly in the hope that it would help them, but they were ambivalent about what happened to them. This ambivalence stemmed from a dissonance between what they expected, what they received and their feelings about the experience. In some instances, these respondents obtained what they wanted, but they found the doctor's attitude towards them as individuals as judgemental, or indifferent or unhelpful in other ways. In summary, these people perceived themselves as having been helped and yet the treatment missing something. Helen, a 46 year old woman, with a history of previous depressive episodes, explained:

> I went along to the doctor expecting to be heard out about my problems and getting some medication. Well, I got both those things, but the doctor's attitude was really judgemental..like he thought I was being silly.

Another respondent, a 39 year old man, John said that he expected some counselling, but was ambivalent about the extent of the counselling offered. The doctor offered him medication, for which John had not bargained:

> I got more than I bargained for. The doctor seemed to be pathologically interested in me and my problems..he insisted I come back...and he obviously thought I was bad enough to prescribe tablets, which I didn't want.

While 43 respondents (11 males and 32 females) sought medical help for their experience of depression, not all of them were satisfied that medical help was useful to them. Their judgements about usefulness related to their expectation of the medical help sought and the doctor's attitude and ultimate treatment of them and their condition.

Some Other Observations

Although I stated in the beginning of this chapter that respondents fell into two distinct groups, the picture is far more complex. Within the two major divisions, 'willingness' and 'reluctance' to seek medical help, are a number of motivating and inhibiting factors which affected the respondents' attitudes. Although some respondents expressed one attitude, for instance, reluctance to seek medical help because of a fear of losing control, others gave a number of different reasons as motivating them or holding them back from seeking medical help. The willingness or reluctance to seek medical help was inextricably intertwined with the respondents' sense of self, their knowledge and perception of the doctor's role, their experiences of social support and their use of other alternative non-medical sources.

The picture is even more complex, when it is seen that those who did seek medical help were not always satisfied with what happened to them. Sometimes, these respondents sought treatment which might better have been given by non-medical professionals. That claim leads inevitably into consideration of the different forms of treatment which were used by the whole sample, but which did not involve consultation with any medically trained doctor. Non-medical treatment for a condition such as depression is potentially available on a 24 hour basis. But what is meant by non-medical treatment?

CHAPTER 12

NON-MEDICAL TREATMENT ALTERNATIVES

The Shorter Oxford English Dictionary, defines 'treatment' as 'management in the application of remedies'. For the purposes of this study, the notion 'treatment' refers to any activity which the respondents believed would alleviate the sense of impairment which they associated with their experiences of depression. More specifically, non-medical treatment will refer to those sources of help which respondents sought or obtained that did not necessitate a visit to a medically trained doctor. The concept 'non-medical treatment' is used in a broad sense and covers any person or activity which the respondents considered helpful in alleviating their feelings of depression, whether the outcome was short term or long term, of temporary or permanent benefit.

Before dismissing the role of doctors in, paradoxically, the function of non-medical treatment, it is important to note that several of the G.P. respondents in these Sydney suburbs contended that many of their patients visited them for non-specific reasons, usually because they thought a doctor could help them in a non-medical as well as medical manner. As a previous chapter on respondents' willingness and reluctance to seek medical help indicated, some respondents in this Sydney study also perceived the doctor as a source of non-medical help and doctors thought of themselves as being able to provide such assistance.

The distinction between medical and non-medical treatment in a doctor's surgery can become blurred. Some of the general practitioners whom I interviewed claimed that they were counsellors and that counselling was a form of medical treatment. On the other hand, other professionals and many depressed respondents regarded counselling and other recipes for recovery as a non-medical activity.

Recipe knowledge

In *the Social Construction of Reality*, Berger and Luckmann identified the fund of objectified and accumulated expertise as a social stock of knowledge, transmitted from one generation to the next and available to the individual to help solve the problems encountered in every day life. They referred to such useful information as 'recipe knowledge' (Berger and Luckmann, 1967).

In Western societies people are inundated with 'recipes' for their depression. These appear in newspaper and magazine articles, in particular in women's magazines. For instance, the following advice was dispensed to readers by one women's magazine: 'Switch to different tasks, take a walk, listen to a favourite record, practice relaxation or an exercise routine. Telephone a friend. Don't give depression a chance... Give yourself a daily dose of success. Think about your talents and interests. Join a society or evening class which caters for a subject in which you can do really well (Cosmopolitan, July, 1987). More recently, in a 'health magazine', readers were entreated to 'Join a club, socialise, and exercise, which is one of the best mood elevators'. Readers were also guided to check their nutrition and their attitudes towards themselves and others (Prevention, February, 1991).

As far back as 1978, some researchers were advocating the benefits of physical exercise as an 'anti-depressant activity' (Greist et. al., 1978; Brown, 1978; Leer, 1980). These researchers looked specifically at running, its physical and mental benefits. Leer claimed, 'Running produces an effect in depressed persons that is similar to the effect caused by tricyclic antidepressants, namely it increases the body's production of neurotransmitter norephinephrine' (Leer, 1980 p.21). Central to Leer's work was the thesis that exercise should be used as an adjunct to psychotherapy for depressed patients. The reason for this is contained in the contention that mastering a physical skill can be generalised to mastery in other areas of life. For depressed patients, therefore, it is hypothesised that exercise will not only make them feel better, but also help in establishing feelings of control in other aspects of their lives.

From an analysis of the 80 transcripts, a number of similar themes about the means of distraction and strategies for regaining control were identified. Before uncovering such themes, it is important to re-emphasise the theoretical perspective of this research. The psychological literature on depression makes constant reference to 'stress', 'life strains', 'self-esteem', 'coping', 'mastery', and 'internal and external locus of control' (Pearlin and Schooler, 1978; Pearlin, Lieberman, Menaghan and Mullan, 1981; Sandler and Lakey, 1982; Ross and Mirowsky, 1989). In this study, the notion of perception is important. The depressed respondents' perception of experiences which contributed to their depression was also a reflection of self-esteem, and included accounts of powerlessness, combined, in some instances, with accounts of experiences of control. There was a sense in which all the respondents felt vulnerable because of their perception that negative areas of their lives outweighed any benefits to be derived from the positives. Yet, respondents also felt that they had access to forms of treatment, even if this comprised something simple like 'having a holiday' or 'finding a mate'.

These forms of treatment were essential to respondents' mental health, if only because, as was suggested earlier, their application resulted in temporary relief. Each respondent reported impairment in their sense of functioning in at least one of the areas of work, relationships or social conditions. 'Doing something' was aimed at producing a better sense of coping in the face of 'boring work', an 'unsatisfactory' relationship or problems in looking after a large home or, conversely, feeling confined and cramped in a small one.

Respondents varied in their perception of the 'usefulness' of their remedies. For some there was an almost 'permanent' result. That is, those respondents who practised 're-ordering' their thoughts said that remedy had often 'changed' their thoughts and views and resulted in alleviation of their depression. However, this is not to suggest that this particular remedy was 'permanent' in its benefits for others. Many respondents used this technique of 'reordering thoughts' in a 'quick fix' manner, almost as if it was expected to have only a temporary effect. Strategies such as 'taking a walk' or 'going for a swim' were used by some respondents in a 'quick fix' way, and by others as a more 'permanent' remedy. A widow of 63 provided an example of how swimming provided her with an almost

'permanent' strategy against her feelings of depression. She said that when she recognised feelings of lowness, she made a deliberate point of embarking on a daily swimming schedule, which she said 'always guaranteed a better feeling'.

The notion of non-medical treatment

Despite the vicious circle that appears to be generated by feelings of depression leading to feelings of hopelessness, powerlessness and worthlessness, people do make an attempt to alleviate their condition by 'doing something'. Ironically, in some cases, 'doing something' might mean 'doing nothing' as in those instances where people 'took to their beds', or avoided having contact with anyone. Sometimes, respondents combined medical with non-medical treatment or progressed from one to the other. A 38 year old woman said:

> I don't know if you can understand the despair I felt, maybe you have to live through it to relate to it. All I know is that the tablets helped - at least for a while. I was taking Serepax and some sleeping pills. After a while I got to thinking about the drugs ruling me - I hate to be controlled - so I went off them. Now, I drink to give me that nice feeling. That extra glass of wine late at night is great in helping me get off to sleep.

In their accounts of 'treatments' and as a reflection of this woman's comment, each of the respondents referred to more than one possible remedy. For instance, a respondent might have sought advice and wanted to talk to a confidant as well as take comfort in their faith, or listen to music, or do nothing. One respondent might have gone to another person for help and support on one occasion and relied upon themselves on another. My second point of clarification concerns the task of describing the meaning of non-medical treatment rather than saying that one activity might be considered more effective than another. For instance, doing something, such as going for a walk, was not being judged by this researcher as better than doing nothing, such as ignoring the problem of depression and going to bed. However, I have distinguished between types of treatment as in the two categories, formal and informal (Figure 12.1).

The formal sources refer to those helping professionals, not doctors, from whom the respondents sought assistance. These non-medical professionals included social workers, psychologists, counsellors (one priest counsellor and one Vietnam Veteran's counsellor) and a naturopath. The category 'informal sources' is much wider: it included lay people, organisations or social groups, and any activity, entertainment, problem-solving skill, thoughts or feelings that helped the respondents' recovery, or which enabled them to prevent any deterioration in their condition. Thus the outcomes of treatment could refer to preventing deterioration, to slight or radical improvement, or to complete recovery.

Several of the formal and informal sources of non-medical help were regarded as supportive, and in the respondents' terms amounted to a form of treatment. However, support while almost always important, was regarded as only one aspect of the variety of non-medical treatment.

Figure 12.1: The Nature of Non-Medical Treatment

Formal	Informal
Listening and talking	Confiding in a key person
Receiving advice	Social interaction
Material aid	Finding distractions
Practical help	Re-ordering thoughts
	Developing hopes
	Self-medication

It is important to stress that in this study the notion 'treatment' refers to activities which are part of the social context of each individual respondent. Such activities are not separate from the person, their condition or their immediate surroundings.

While not every respondent spoke of both formal and informal activities, they all had individual repertoires which included at least one, and usually many more, activities. One respondent spoke of the benefits she derived from talking with a social worker as well as the positive effects she felt when listening to music and, on other occasions, when she made an 'effort to think of all the reasons not to

be depressed'. Another respondent, a man who had migrated to Australia many years earlier, said he used correspondence, 'writing letters to relatives and friends back home', and a technique he called 'reminding myself it will pass' as antidotes to his depression. Still another respondent, a single mother, spoke of the benefits of 'reading a light or trashy book', as well as 'eating something sweet'. This woman also referred to the positive effects she felt when she did something simple like meeting an old friend for a cup of coffee and in her words, 'getting some moral support, sympathy and reassurance that I will turn the corner shortly'.

What follows is a closer look at the different activities identified by the respondents as having anti-depressant effects. Formal sources of non-medical help will be explored first.

Formal sources of non-medical treatment

There were three different pathways to non-medical professionals. Doctors had referred some of the respondents to social workers, psychologists and counsellors. Friends and relatives who had been to see such people and found the experience helpful had suggested to their depressed peers that they should also seek such help. Thirdly, there were those respondents who walked into a community health centre hoping they could be helped: these were self-referred.

In all, twenty eight respondents went to see a non-medical professional, via one of the three routes discussed above. They included 18 women and 10 men, whose ages ranged from 17 (a female) to 67 (also a female). Fourteen respondents sought help from a social worker, nine from a psychologist, four from counsellors of various sorts and one from a naturopath (Table 12.2).

Table 12.2: Sources of Formal Non-Medical Help

Referral Sources	Non-Medical Helpers				Totals
	Social Worker	Psychologist	Counsellor	Naturopath	
Self	5	4	3	1	13
Doctor	5	3	1	-	9
Friends	4	2	-	-	6
TOTALS	14	9	4	1	28

'Counsellor' is a generic term which refers to a helping professional who offers a counselling service. Counselling is a term which reflects a wide range of activities, depending on the theoretical orientation of the counsellor. Those respondents who had seen a counsellor spoke of the experience as involving talking, listening and support. They described different people as counsellors and qualified what they meant by the term counsellor. For instance, one respondent spoke of having gone to a specific counsellor who specialised in assisting Vietnam war veterans. Another respondent was referred by his general practitioner to a sex counsellor for his 'loss of libido'. That counsellor was also part of a group of researchers in a University department. A third respondent talked of having sought help from his priest who was also a trained counsellor.

In common with themes in social work literature and with the comments in practitioners' everyday conversations, the respondents in this study did have specific observations to make about their experiences of the process of counselling. In a later section of this chapter, the context and content of such counselling will be summarised in terms of the respondents' perceptions.

Irrespective of what pathway led these respondents to their respective non-medical professional helpers, they all recalled hopes and expectations of the encounter. This was the case especially when they were referred by someone else - their doctor or acquaintances who made a recommendation on the basis of a positive experience themselves. Having made the effort to see such a professional,

all the respondents were in a position to comment on the helpfulness of that experience. They all had specific views on the nature and benefits of such an exchange.

Hopes and expectations

Some respondents' hopes and expectations of what they would gain from an encounter with a non-medical professional were hazy. Others had firm ideas which had not always been met. That did not mean that their experience was recalled as unhelpful. For instance, those respondents who expected to receive 'advice' and were not given it had to reassess the benefits of whatever help or guidance they did receive.

Respondents described their attempts to obtain help with their depression in terms of looking for the opportunity to talk about their problem, receive material help, advice, guidance and support. These were not discrete expectations and often one respondent expected all these benefits. There were others who spoke only of the need for the opportunity to be listened to, or to be advised.

In these expectations, the experience of seeking non-medical treatment had in common the underlying need of the respondents to either be engaged in or guided in their problem-solving, to overcome their sense of impairment. They wanted to regain control and to feel more powerful. By speaking with a professional they hoped that their problem would be addressed, if not solved. The respondents were not ignoring the problem. They had the desire to work out what was happening and to either do or have something done on their behalf. Contrary to the findings of Wetherington and Kessler (1986), the respondents in this Sydney study reported that actually talking to others and receiving advice, comfort, practical help and 'cheering up' was helpful.

From the respondents' accounts, it is apparent that the connotation of the language they used was important in explaining what they regarded as helpful treatment. They wanted to 'be encouraged', to 'regain control' and to 'feel more powerful'. They did not regard as helpful those experiences in which they perceived the 'helping person' as merely trying to please them. Neither did they

appreciate being told to 'pull themselves up by their bootstraps' or assured that 'everything would be alright'. They wanted neither reprimands nor false assurances. They did not want to be merely 'pleased' or 'appeased'. One respondent said that appeasement was her way of describing unsatisfactory encounters with friends. More was expected from the counselling encounter with a professional.

The respondents' accounts showed that the context in which help was offered was perceived as relevant and potentially empowering. The descriptions of each context referred to time, space and a degree of empathy. They talked about 'avoiding a feeling of being rushed', 'having someone with time to listen' and appreciating the 'time and the feeling of being listened to'.

Talking about problems

Community surveys have found that depression decreases as one's sense of control over key activities increases (Wheaton, 1980; Pearlin, Lieberman, Menaghan and Mullan; 1981; Kohn and Schooler, 1982; Turner and Noh, 1983; Mirowsky and Ross, 1983, 1986;). All of the twenty eight respondents said they wanted to talk about their problems and so replace their depression with an element of control. Some commented that they perceived doctors as giving limited time only and they wanted more space with someone who had 'time to listen'.

By talking about their sense of feeling low, many respondents reported they felt more in control and recognised themselves as having more options than they believed they had. Typical of this response was Michael who said:

> Having the sort of problem I have and feeling so low about it made it difficult to talk to people, you know? I had sort of run from it....but talking to someone who understood and was professional about it....well it made me realise I wasn't the only one. I could do something about it....I'd sort of given up hope. But the counsellor encouraged me to talk honestly and said we could set up a program for me to follow to help me get over things.

In common with Michael's observations, Janice felt unable to be 'totally frank' with her doctor. This doctor had referred her to a social worker, who, in the doctor's words, 'will have the time to uncover some of the reasons for your depression with you'. Of that 'uncovering experience' she commented.

> It's such a relief to have all that's locked up inside you just spill out....the doctor never gave me a chance, and besides, he's not a really sympathetic type, and he's also my husband's doctor, so I couldn't really tell him everything... spilling my guts, I called it, but it felt better and I learned that I wasn't stuck forever, things could change....it was a feeling, like, that things would not always be the same.

A more ambivalent appraisal came from Kathy, who was wary and uncertain as to what to expect from the social worker. The end result had been positive, but talking things through had been painful. She explained:

> I suppose it started off between us a bit like pulling teeth... I was reluctant to talk freely....it's not easy, telling people how awful you feel... I was aware of the social worker pushing me a bit and me resisting it at first, but once I started talking I felt myself freeing up....that business of talking and getting something back is unique. You don't get it with friends - you know, often friends just want to please you and go along with everything you say, or more like appease you....but the social worker pushed me to talk things through, even when they were painful....funny thing is I felt so much better once it was all out.

This notion of talking about problems and having what has been called, somewhat clumsily, a 'dialogical relationship' with a professional helper was perceived as beneficial, even in the absence of actual 'advice giving' by that professional. Kathy hinted at this but others were more explicit. Lucy had experienced only negative relationships with doctors and psychiatrists, whom she found were not interested in her and how she coped with her life. Being a resourceful person, she discovered that the local community health centre was a place where she might be listened to and taken more seriously. When she went to that health centre she was assigned to see a psychologist. She had only had expectations of seeing a non-medical counsellor, and the fact that she was seen by the resident psychologist was not of her choosing. However, as it worked out,

Lucy found the exchange with that professional positive, partly because of the process, which she described:

> I found the counselling very satisfying....I was seen as a whole person living in Sydney, but missing my home in Chile... I was not seen as a depressed case. I knew I wanted to talk perhaps instinctively I knew it would be therapeutic. I don't think I expected advice and I didn't really get any....except that by talking to a professional who knew what to say and when to say it I felt more able to solve the problems I had. It was like I had my own advice inside me ready to come out when someone pressed the right button.

This feeling of benefit from consulting a non-medical professional for the purposes of talking out one's problems was echoed by others. Some of these respondents emphasised that the actual process of talking with the professional was 'therapeutic'. For example, Kay explained:

> It was a relief to be given the time and courtesy of being listened to....I didn't feel any rush to get my story over and done with. Just talking about it with someone who was paying attention to you felt good.

Kay was typical of those respondents who found that talking to a non-medical professional was different to talking with doctors. Time and again, it was pointed out that while doctors appeared to have little time to devote to listening to problems, non-medical professionals were willing to do so. Even when respondents saw this willingness to listen as being 'part of their job', they appreciated it and valued the benefits. As Jackie, a 37 year old married woman who worked as an accountant said:

> Even though it's part of their job, I found that talking to the social worker was more satisfying than I ever found talking with my doctor. With him I always felt rushed....it's hard to unravel all the things bugging you when you know the clock's on you.

Even though there was a sense of time and space provided by the non-medical professional, for some respondents there was another qualitative difference: as between time given by friends to talk and the same sense of freedom being provided by a professional practitioner. In addition, they reported

that the emotional distance between the respondents and the helping professional accounted for at least some of the experience of talking with a professional as being different from speaking to one's best friend. For Louise:

> You feel more free to tell the professional person about yourself....I'd be too embarrassed to tell my husband or my friends how I feel....they wouldn't be able to help me sort things out as well.

Brian described talking with a psychologist in the following terms,

> Things seem clearer once I've had a session with her....I do most of the talking but she listens and asks the right questions....its a matter of training and timing as I see it....you wouldn't expect your wife to be astute enough to do as good a job....besides, its a different relationship....you don't have to worry about what you say upsetting anyone's sensibilities.

For these respondents a session with a non-medical professional was therapeutic because it allowed them to talk freely about problems and their fears and sense of depression. There was a suggestion that the actual process of being seen and being able to talk was beneficial, irrespective of what the non-medical professional did. There appeared to be some benefit attached to talking to someone who was neither personally known nor close to the respondent emotionally.

The process of relieving stress and a feeling of lowness by verbalising, or talking about thoughts, feelings and problems, was all some respondents said they needed and wanted. Others expected more. They wanted 'advice', to be told what to do, which way to go. Those respondents who said they felt positive benefits from having been advised by a non-medical professional said that in the process they had been given a greater sense of control over their problems.

Seeking advice

People who are distressed, anxious and depressed often will seek to 'figure out the cause' and 'get some advice'; activities which are a form of problem-solving, albeit with a hint of dependence on others. This, of course, is not to decry the

necessity for such activity by depressed people. Seeking advice appears at first sight, the opposite of self-reliance, but for the depressed person it is often necessary to rely on someone else before they can rely on themselves. This point is made because some respondents were critical of themselves for needing to go and seek 'outside help', yet they conceded, reluctantly, that they felt they had no alternative.

Other respondents spoke clearly about their need and desire to seek formal non-medical help to get advice and thereby enable them to achieve a greater control over their lives. Kim, described the initiatives she had taken:

> (To) Sort myself out....I needed to figure out why, what was happening was happening... I wasn't up to that task by myself....besides I needed to get some advice on what to do about it....when you're in the middle of it all its hard to see the forest for the trees....the social worker didn't have the answers, but she gave me some suggestions and hints about how things might change....she got me to keep a diary of activities and thoughts and feelings on them....to see how things changed as I felt stronger and less squashed by life.

Keith also went to see a social worker at a community health centre because he was 'at the end of my tether'. He was in receipt of worker's compensation payments and caught up in a medico-legal case which he found debilitating. This added to his feeling of being 'on the scrap heap' caused by being forced into a virtual early retirement. In his words:

> I went to see the social worker for advice, because I felt I couldn't cope and go through with the circus I had been thrown into... I didn't think I was loony or anything, but I needed to talk and get advice on how to keep afloat physically and mentally. After 4 sessions with him I felt better able to cope because all the time he advised me that the answer really was within me....got me feeling more confident and able to take charge again.

The alleged claim by this social worker and indeed by other non-medical professionals that the solutions were within the person raises the major issue in the whole notion of treatment. On the one hand, these respondents identified a range of social issues which contributed to their depression. These contributing

factors have been discussed in terms of people's role performance as elaborated in the impaired social functioning typology. Yet the very concepts which highlighted social issues were apparently ignored when non-medical treatment alternatives were raised. To put it bluntly, the respondents had discussed social issues, the means of help offered them focused on individual problems. This is perhaps not surprising given that individualistic-style remedies are culturally and professionally sanctioned. In this respect, it seems that some of the non-medical treatment alternatives were as irrelevant to the respondent's conditions as the medical treatment which has been previously criticised.

Sheree was another respondent who sought help in order to get advice. She went to the psychologist not wanting 'tablets or other mind-bending techniques', but:

> Advice, pure and simple, on what to do....there had to be a key to the problem....it wasn't that she actually told me what to do, but we talked and things, advice, just seemed to emerge from the discussions....I also kept a diary for a while recording my thoughts and actions... It gave me a sense of getting on top of it all again.

For some respondents, the expectation that advice would be dispensed and somehow would change their lives forever did not materialise. In Marg's case, the disappointment related to not getting 'some concrete advice' was linked to her sense that she was powerless to change things without such advice. She said:

> I went to see the social worker wanting to be given some concrete advice, told what to do, in other words, I wasn't in a position to make decisions myself. But she didn't give me what I wanted....I recognised her technique, she tried to get me to see I had options and then to decide what way to go....but what I wanted was to be told.

Several respondents wanted direct advice. They wanted to be dependent on another person, however temporarily. In this respect, one respondent talked of needing to relinquish control in order to regain it.

Tony, argued that temporarily relinquishing control and allowing oneself to be influenced by another, was empowering and helped the depressed person in the long run. Without this ability to heed advice, a depressed person might become even more immobilised. He explained:

> I know that asking for advice might seem to be a cop out, but when you've bottomed out yourself it's hard to get the energy to formulate advice to oneself....by relying on someone else, like the priest who's a counsellor I saw, I got the strength to solve the problem myself ultimately....its a matter of short and long-term views....you might need advice in the short-term, but sooner or later you develop a sense of confidence and control over your destiny.

For these respondents, seeking and receiving advice was related to achieving a greater sense of control over their lives and environment. For Lillian, the need to receive advice was coupled to a hope of receiving material help. Lillian was a single mother, with three children and earning a small, part-time salary. Two other respondents, Freida and Sandra also sought material and practical help.

Asking for practical help

Lillian said that she recalled 'seeking both advice and material assistance'. When she went to see a social worker,

> I wanted to know how to deal with my abusive ex....he was coming around and hassling us, so I needed some advice, because we were frightened... But I also wanted to know where I could get some vouchers or some help with groceries. I hate charity, but we were near to starving, most of the money went on rent....the social worker arranged for someone from St. Vincent de Paul to come around and give us some help.

Sandra said she had needed practical help. Her only source of income was a pension and with this she had to care for three adolescent children, all of whom were still at school. Her only 'salvation' was the Housing Commission house she recently moved into, for which she was paying a small rent. After months of feeling low, a friend suggested that a social worker might be a useful person to see. In her words:

> Talk about depressed, I thought if I could get a job or be retrained or something, our situation would improve....so I went to the social worker for advice and she suggested I might take on day-care mothering work... I also needed some practical help with getting to Goulbourn prison to visit my boyfriend...the social worker put me in touch with the special bus that goes there every fortnight....you may as well go to the professional people, because they've got the know-how.

Another respondent who sought practical help, again from a social worker was Freida, a 67 year old pensioner. Freida lived in a retirement village to which a social worker came twice a week. Freida said:

> I wanted to know if the social worker could arrange to have someone visit me at the home....perhaps someone I could go out with, shopping or to the movies....someone more my age. I'm one of the youngest and most active people at the home and I want to get out because I get so depressed there.

The sense of control which each of these three women gained, related to their being able to change some aspect of their environment or social circumstances. Each wanted some practical or material assistance, at least in the short-term. Not only was advice and practical assistance important to such respondents, so too was a desire to gain a sense of emotional support.

Gaining support

Those respondents who spoke about gaining support from a non-medical professional described their positive experience with reference to 'trust', 'understanding' and 'concern'. They were describing the relief they gained by talking and having someone listen to them. For example, both Craig and Noel seemed to benefit from the experience provided by talking to non-medical professionals. Through this process they gained a sense of support, by which they meant sharing problems - 'not being alone'. For Craig:

> I thought I wouldn't get as much out of counselling as I did....the social worker was sensitive to me and my predicament and there was this real trust, so I felt I could unburden to her.

In Chris's case, there was an expectation that he would gain advice and support. His words also revealed that the feeling of support was closely related to talking things through with a helper, in this case, a psychologist:

> You know how difficult it is to sort things out when you're totally confused and feeling in the pits....talking about things and getting some ready-reckoner advice gets the motivation going again....once I felt supported I felt re-born and much more able to cope with things again.

Noel recalled his encounter with a 'counsellor':

> I felt a sense of support, a sense of confidence coming from the counsellor and it made me feel stronger....she was understanding....in fact, I was surprised how much I revealed to her....she had a knack of getting things out of me.

From comments such as those of Craig, Chris and Noel, it is clear that non-medical professionals who 'elicited things' and helped depressed people feel they could cope, perhaps even feel 'reborn' provided a helpful service. This sense of coping, even amounting, for some, to a sense of power, seldom came from a one-off encounter with a professional, but mostly from a series of such meetings. All but four of those respondents who had meetings with non-medical professionals went more than once. Over half of the twenty-eight had at least four meetings with a professional helper.

This notion of support and understanding leading to a sense of coping was also claimed by those respondents who spoke of the benefits of an exchange with one key person in their lives. This key person was not a professional but rather a person known to, and trusted by the depressed person. As such, I have labelled this interaction an informal source of non-medical help.

Informal sources of non-medical treatment: doing things for themselves

In the following discussion of informal sources of treatment, I shall repeat ideas which were documented under the heading 'formal sources'. This is not surprising. In one form or another, counselling was present in the activities of both formal and informal sources. At least implicitly, the notion of empowerment and the process of empowerment were also used by a variety of people, professional and lay: at least some respondents referred to their encounters in these terms.

Confiding in a key person

Conventional wisdom has it that human beings need to confide in others, or at least one other. Expressions such as 'no man (sic) is an island' and 'getting it off one's chest', to name only two, attest to this. Self-disclosure is an aspect of confiding which has been described in social work literature for many years. In the 1960's, psychologists adopted this concept of self-disclosure and attempted in research to measure personal adjustment. In the last fifteen years, a different perspective on the role of the confiding relationship has been taken up by researchers into the stress-buffering role of social support in the face of adverse life events.

Brown and Harris (1975), found that the lack of a confiding relationship with a husband or boyfriend increased the risk of depression in the presence of a severe life event or major difficulty. Other studies have replicated these findings (Surtees, 1980; Henderson, 1981; Campbell, Cope and Teasdale, 1983).

For the respondents in this study, confiding meant the ability to talk through their problems in a confidential manner with a significant person in their lives. As a result of this 'talking through process', they reported that they felt a sense of acceptance by and support from that confidant.

Such language suggests that the respondents saw the confiding relationship with a significant other as having some characteristics of counselling. Both formal

and informal sources of help gave respondents a feeling of being respected, accepted and supported: some key ingredients of good counselling practice.

The value of 'confiding in a key person' had a common thread. It concerned the use of a relationship with a significant other. This was usually a peer, a friend but sometimes a family member, for example, a wife, husband, mother or sister. No respondent mentioned their father as their confidant, and only two men considered their brothers in this role.

The importance of confiding was epitomised by Karen, a woman of 40, twice divorced and living alone:

> Everyone needs someone to talk to, but I don't want to wash my dirty laundry in public, so I choose who I speak to about my problems... I have a close friend I've known since we were both teenagers, she's also a single mother and she can understand my sense of anguish.

Another respondent, a male of 56 said:

> I feel safe after I've unloaded to my confidant. I've known her for 25 years and she's a very warm, accepting human being... I could confide anything in her.

This respondent, who had decided he was homosexual after a 30 year marriage in which he and his wife had brought up three children, was disappointed by many of his friends' and relatives' responses to his altered status and life-style. However, the friend to whom he referred had remained loyal and accepting over two years and he had found confiding in her supportive.

These respondents emphasised the importance of loyalty and acceptance by their confidants. Feeling accepted and respected by their confidant even when, as one woman put it, 'you're a bloody drag' was a crucial feature of the interaction. This young woman, Sue, aged 28, felt housebound and frustrated not only with her environment, but also with her relationship. In her words:

> You know you've got support when a friend accepts you even when you're a bloody drag....even in my darkest moments, when I've felt paranoid and like I could be rejected, she's given me her acceptance.

Another woman, Ruth, a doctor of 33, spoke about her close bond with her husband and how their relationship has provided her with the emotional support necessary to continue 'after some fashion'. She added:

> Robert has been my saviour - he's been there and helped me through thick and thin....I can reveal anything to him and he accepts me for who and what I am....there's a feeling of acceptance.

The respondents who spoke of the value of having a confidant, identified several ingredients in these relationships. In social worker parlance, these ingredients are often given the short-hand name of 'unconditional acceptance'. However, the respondents did not use such language. They spoke instead of several necessary conditions. First, there was a sense of having to know the person. Secondly, a sense of trust was important. These factors led to feelings of acceptance and a sense of safety in 'unloading' problems by the depressed person. Some respondents used words such as 'being in tune' and 'on the same wavelength' to convey the symbolism of confiding 'in confidence'. The language of the following two respondents illustrates these points.

The wider social network of a 64 year old man, Ken, offered him 'general support and comfort'. More important was one key person with whom and from whom he felt empathy. In this words,

> You can talk to a thousand people about your depression, but if they're not sensitive to it then you may as well be talking to the wall. Look, I've got lots of people around me I could ear bash about this and that, but what's the point? All I need is this one person who's on the same wave length and I'm right.

In the language of another respondent, a woman of 36, who described an 'ambivalent relationship' with her husband:

> Sometimes you just need to tell one other person how miserable you feel, it's not that you expect them to do anything, just to listen and

try to understand, that's enough. I use my sister for this, she's really in tune with me.

The need to find acceptance and a feeling of support from relationships was also evident for those respondents who found solace in what I have termed 'social interaction'. This refers to those situations where respondents sought a 'collective remedy' for their ills by seeking out company and socialising.

Social interaction: collective remedies

Social isolation characterises the persistence of chronic depression. Social interaction which alleviates this isolation has positive effects which can be viewed as a form of treatment. Thirty-one respondents, a majority of whom were migrants referred to the value of close association with others of similar background and interests: they emphasised experiences of meeting and exchange which involved general socialising, task-focused group activities, or a combination of both.

The general socialising included visits to a pub, a club, going to dances, to dinner or picnics. While the visits to the pubs and clubs might be casually arranged events, the dinners and picnics were more formally arranged by clubs, such as ethnic based ones. Such clubs organised events which gave people the chance to socialise with other migrants and to speak in their own language about their country and culture.

Task-focused group activities were described by ten respondents, again mostly migrants. These groups had a specific purpose, very often a political one, and were organised by ethnic groups. Such group activities provided the opportunity for people to discuss events in their countries. They enabled them to 'keep in touch' and included religious worship which was integral to many migrants' lives. A 67 year old Russian woman had experienced isolation and depression in the past and particularly since her retirement two years earlier. She and her older sister, who was an invalid, migrated to Australia 25 years earlier. The availability of religious leaders in the Russian community and the church activities she could attend were central to this woman's life. She said that

religious leaders were a valuable resource she could call upon. She regarded their interest in her as a form of social support. In addition, regular church attendance made her feel 'more secure'. Both events helped this woman through some extremes of depression.

For other migrants, the power of peer group support and membership of an ex-patriot group was experienced as supportive. A 44 year old Chilean woman said:

> I get more from talking to people from my own country than going to see the psychiatrist....we meet and discuss the situation in South America, we are all people in a similar position and we understand one another. I look forward to going along to the group meetings.

The essential characteristic of the non-medical treatment being described here had to do with the value of a sense of reciprocity in groups. Such experience provided an indispensable means of reassurance that people belonged to a group, a culture, and a country.

In the following discussion, I shall explore those remedies which the respondents pursued, mainly alone, sometimes with one other, but rarely in groups.

Finding distractions

Distractions as non-medical alternatives included listening to music, taking a walk, going for a run, going swimming, rearranging furniture, painting and decorating the house, reading a book, playing a game of cards, going to the movies, going shopping, meeting friends for coffee, lunch or dinner, watching television, sleeping a lot, eating special treats, such as chocolate. Some of these activities involved physical exertion while others called for inertia, for passive behaviour. Whether active or passive, these activities had a common quality of distracting the respondents.

This point was implicit in most accounts, but several respondents were explicit about it. Tanya, a 63 year old widow said:

> I take myself off for a long walk, it helps me clear my mind....or I go to the pool and do 20 laps, not thinking of anything except the sensation of pulling myself through the water.

Another respondent spoke clearly of the value of activities which distracted him from feelings of depression. Ken, a 64 year old widower who worked as a foreman said:

> I find that if I can distract myself I feel better, at least for a while. I usually listen to some jazz, or sometimes go to the club, so I'm surrounded by people and sounds....I often meet people there I know and we have a chat and perhaps play the pokies.

Marilyn, a 56 year old divorced woman who worked as a welfare worker, saw the irony of regarding sleeping as an anti-depressant activity:

> The best thing I can think of doing is not doing anything except sleeping a lot....that's almost a contradiction, but sleeping is an activity, or least an act. At least I'm doing something, even if its nothing.

Although she did not say so in as many words, Marilyn perceived sleeping as helping to take her away from her depression. She did not elaborate the temporary nature of sleeping as an anti-depressant activity. What happened when she woke up? How long did the effects of the remedy of 'sleep' last for her? She did say that sleep made her 'feel better for a while': it was a temporary distraction from feelings of depression.

For several migrant respondents, taking comfort in their faith was a crutch, a source of comfort, sometimes an inspiration. It is in these respects that the use of religion might be considered a non-medical form of treatment. An elderly Russian migrant woman who lived with her older sister said, 'going to church makes me feel good....much better when I feel low in spirits....it gives me faith.'

Another migrant respondent, Claudia, who came to Australia as a child from Italy, saw a link between an improvement in her feelings and her desire to pray:

> Praying is good for my mood, if you believe, like I do, if you have faith in God and the saints then it lifts you up. I don't mean going to Mass or anything, just going to the church, praying quietly and lighting some candles.

Whatever the nature of the 'distraction', it brought the respondents a sense of achievement, enlightenment or merely, in their terms, a temporary 'good feeling' which helped alleviate some of their sense of impairment. 'Re-ordering thoughts' was another form of treatment which the respondents 'did themselves'.

Re-ordering thoughts

When psychologists or social workers speak of encouraging people to re-order their thoughts, to replace negatives with positives, they refer to a technique known as cognitive therapy. Such a label was not used by the respondents, though at least twenty referred specifically to their attempts to 'try to think in a different way', 'to imagine I'm not depressed', 'to meditate and relax', 'to exercise some self-control', 'to conduct self-analysis, so I can think differently'.

June, aged 65, a widow, spoke of her attempts to 'work things out':

> When I catch myself thinking negatively, I pull myself up and try to turn my thoughts around - be more positive about life....at first, it's like a false feeling, but then I start to really believe things can get better... I tell myself good things must be around the corner....and then gradually I feel better....it works quicker sometimes than other times....how long it lasts also depends....maybe a day, sometimes a week, sometimes longer....there's no pattern, except that it works for me.

In this revelation, June tells us that she has found an activity, 'thinking differently and more positively', which worked for her. Although she claimed it had desirable effects, she pointed out that the duration of the benefits varied. This is an important point: different activities had different effects and the duration of benefits varied for individual respondents. No definitive claim can be made as to how long the positive benefits of any one activity lasted.

The interrelationship between thoughts and feelings was echoed by Emil, aged 41:

> I tend to block out my feelings of depression....I think of other things, beautiful, pleasant things....then I start to feel much better....later I can think about my problems and they don't seem quite so bad.

The process of re-ordering thoughts could occur retrospectively, when someone analysed why they had behaved in a particular way. May explained:

> Sometimes I take things, feelings, frustrations out on the children or the dog, sometimes my husband. It is not until after I have done or said something vile that I realise it was because I felt low. I usually feel better for thinking about it, but sometimes I feel guilty.

More predictable activities to re-order thoughts were described with reference to the value of meditation. Jack said:

> Simple techniques of total relaxation through thought and breath control gives me a feeling of control. I find meditating as often as possible counteracts my feelings of depression.

Beth, 37, used an even more simple type of relaxation,

> I stopped going to the (yoga) class, but when I've felt really down, I've put on a relaxation tape. It's only a twenty minute tape but it takes you through relaxing your whole mind and body.

Whether the purpose of such relaxation was simple or sophisticated, these respondents found that the act of devoting time to concentrating on nothing more than relaxing body and mind was enough to make them feel better, at least temporarily. For a time at least the constraints of work, or relationships or social conditions seemed manageable.

The way these respondents said they used their thoughts and feelings to help themselves varied. Kicking the dog and feeling better by taking one's negative emotions out on something, is very different to attempting to feel better by achieving control through thinking and analysing the problem, which is different in quality to meditating and relaxing. Whatever method was used,

respondents said they improved their self-esteem at least temporarily, for they felt more in control and less vulnerable. In their terms at least, feeling more in control appeared to be the same thing as being 'less vulnerable'.

By re-ordering thoughts, respondents implied that their lives became more hopeful. For a time at least their sense of impairment was diminished, if not alleviated. Another activity which the respondents identified as helpful was the experience of developing hopes.

Developing hopes

One difference between those who struggle with the burden of depression and those who commit suicide is, arguably, that the latter have apparently seen no relief to their pessimism. In this respect, the notion of developing hopes and wishes and indulging in fantasies was important, even though such thoughts were not realised. The development of hopes represented treatment not so much in the sense of getting better but as a way of conjuring reasons for avoiding getting worse. Migrant respondents expressed this point of view. Sovyn, said, I mostly dream of going back (to Cambodia).

Other migrants felt similarly, including two White Russian men who regarded themselves as 'lost people', and wished that they could be accepted by their new country and so be enabled to settle. Returning home might well have been a fantasy for these migrants, but it nevertheless gave them some sense of optimism, and helped alleviate their depression. In the case of Lucy:

> I'll never forget Chile....it is still my home....I know it is unrealistic of me to want to go back, even dangerous, but I have a desire to... Memories of Chile often help me when I'm feeling depressed... There are so many bad memories, yet there are also wonderful memories to cherish.

Migrant and non-migrant respondents expressed hopes, for a better job, for more pleasant physical surroundings, a more comfortable home. The difficulty was that few of the formally organised services could address these issues. So people fell back on their hopes that their luck might turn one day. Fantasies such

as winning Lotto or the lottery also sustained some people through bad times. In the case of Phylida, 48, a nursing sister with a keen interest in grey hound breeding and racing:

> Seeing one of our dogs win a country meeting lifts my spirits....who knows one of them might win at a big city meet one day... I also play Lotto, hoping for the big one....I'm sure my life would improve.

Terry, a single mother with a 10 year old son said:

> I buy lottery tickets and hope to win. It would put us out of this mess, we could buy a nice home, even getting a better job would help. I'm hopeful that will happen but the lottery is a long shot! You've got to have dreams and hopes though, otherwise you'd go under.

Such hopes, wishes and fantasies helped some respondents stay buoyant, and not 'go under' as Terry suggested. Terry, as well as many others also mentioned the hope of finding a mate. For Christopher, 56, the hope of finding a loving relationship often kept him going:

> I'm the sort of person who needs a loving, caring relationship....to be with someone whom I love and respect and who feels the same for me. I've got the beginnings of one, but I have to work on it....it's draining, but at the same time the hope of getting there gives me a buzz.

Bryony, 22, had been 'dumped' by her boyfriend, and for three months afterwards, said she felt suicidal. At first, she recounted how she hoped that there would be a reconciliation. She would fantasise about that, but as the prospects dimmed, she began to hope and fantasise about just being in a relationship, 'any relationship'. She said:

> When I was so unceremoniously dumped, I was totally flattened. Then I began to hope and wish we could get back together. it occupied a lot of my thinking time. Then as all that faded well, I began to fantasise about being with someone else. At first that was just a fantasy, but then I started going out and I've got some good prospects, but not a solid relationship yet.

Bryony was expressing a view that if someone cared for her she would feel better about herself, hence her hope of a 'relationship.'

At first glance it might seem inconsistent that hopes, wishes and fantasies should be regarded as 'treatment'. The notion 'treatment' pre-supposes some planned intervention, or some carefully considered initiative. However, if 'treatment' is considered in the broader sense as suggested in the opening paragraph of this chapter, then unplanned activities, even if they appear to lack any careful premeditation, can be termed 'treatment'. A caveat to this point is that the activity should be seen by the respondent as helping to alleviate their sense of depression.

In many ways, all the initiatives just discussed were self-prescribed. The next source of non-medical treatment was also a prescription from the depressed respondents to themselves, although in these instances, it refers to prescription in the usual sense of the term, that is, taking tablets, potions and pills. In the following discussion, 'medications' is used loosely and applies to all those substances which the respondents took, of their own accord, in the belief it would make them feel better.

Self-medications

The substances which respondents prescribed for themselves included alcohol, food, especially sweet foods, health food and naturopathic remedies. While more men than women mentioned the use of alcohol as helpful, this was by no means exclusively a male remedy. On the other hand, only women spoke of their desire and need to use food to soothe themselves. To some extent these might be socially conditioned responses. Over a third of the female respondents used this remedy. For some women it provided 'the answer' to feelings of depression, but sometimes set up another cycle of 'feeling bad'. The irony of this did not escape some female respondents.

Katherine, a 56 year old divorced woman, living alone commented:

> Since my first bout of depression about five years ago, I've gained two stone in weight... Food, especially sweet things like cakes, biscuits and chocolates to make me feel good....and mostly it works....I can eat my way out of my troubles.

For other women, using food as a way out of their difficulties proved to be part of a vicious circle. Terry said:

> I eat when I'm depressed and look what's happened... I used to be a size 10, now I'm a size 18 - I often don't recognise myself if I glance in a mirror quickly, I can't help it, its a quick fix... The trouble is, I feel guilty eventually and sometimes that depressed me.

Other women used alcohol as a 'quick fix' remedy. They found that alcohol enabled them 'to relax', to 'get away from feeling bad', as 'a sleep option,' but they seemed to question their role as drinkers more than the men did. For Janice, 36, there were difficulties and questions:

> I didn't think it was a problem using alcohol to help me relax, get away from feeling bad and almost like a sleep potion. At first, it was all right, but then I began to worry that I would end up an old soak... I use alcohol more carefully now, but it is a help when I'm at my worst.

But like the resort to food, this remedy had repercussions. The hang-over effects of too much food or alcohol ensured the persistence of feelings of depression, even though they gave some sense of temporary high and thereby relief.

For men, there was not much questioning, let alone explicit criticism concerning their use of alcohol. Tony, 26, and Michael, 41, said that, for them, judicious use of alcohol was the best remedy they could think of. According to Tony:

> By having a few drinks of a night, I can put my worries behind me and get on with the evening and get to sleep... I don't get roaring drunk....just relaxed enough to cope....it's better than taking nerve tablets or sleeping pills....once you start down that track you're gone....having to rely on tablets to keep you going or to get you to sleep is not natural.

The idea of 'having a few drinks of a night' was among the several 'natural remedies' referred to by some respondents. For example, several women and one man resorted to 'natural' and 'health' remedies and medications like vitamin tablets, powders and herbal teas to help them. Greg, a 56 year old nursing administrator, was convinced that herbal remedies, like tablets and teas were an answer:

> Prescribing myself relaxing herbs lets me take some responsibility for my condition....it's a much more gentle way of dealing with my depression, than taking artificial substances.

The use of self-medications might appear haphazard and unlikely to be proved effective in any scientific evaluation, but that was not the objective of these respondents' solutions. They wanted to be able to relax, to feel free of stress and to improve their sleep. They wanted to exercise some control over their treatment, if not their fate. Self-medication met those criteria.

The nature of non-medical treatment

In the respondents' own words, non-medical treatment comprised activities and actions which 'developed a sense of confidence', 'achieved a greater sense of control', and helped them 'get strength'. More specifically, non-medical treatment involved 'having dreams and hopes', 'going to church', 'praying', 'doing meditation' and 'wanting to be told what to do' when depression had immobilised them.

The last 20 years has seen the rise of 'alternative' remedies and practices, in relation to mental and physical health. In part, this alternative health movement has been a reaction to what has been perceived as the unhelpful, because irrelevant, nature of conventional medical practice. What emerged from these respondents' accounts was an emphasis on the value of opportunities for self help. In their terms, the 'alternative' health movement was sustained by the desire of the person with the 'dis-ease' to play a larger role in their own treatment.

In example after example, the respondents talked about their interest in helping themselves, wanting to be more involved in their recovery. Others implied

the same thing. All 80 respondents had at least one 'recipe' and their attraction to non-medical treatment alternatives often involved wanting to achieve more control over their lives and thereby enhance their sense of social functioning. Ironically, the 'control' they sought sometimes meant 'giving up' control to another, at least temporarily. Here the concept of 'social support' assumed a central place in treatment alternatives. On other occasions, the notion of support was more implied than discussed explicitly. Nevertheless, references to the need for 'support' seemed to lurk everywhere. Support was seemingly an ingredient in many, if not all, of the respondents' recipes.

The importance of support

When referring to an improvement in their roles at work or at home, respondents identified the significance of different forms of support. That is, when respondents found an activity supportive, they experienced some positive benefit in terms of their sense of social functioning.

Respondents found talking about their depression, being listened to and given advice, supportive. When material help and practical assistance was given, the respondents also reported having a sense of feeling supported. It would be hard to argue that the sort of activities the respondents spoke about under the banner of 'social interaction' would not also be experienced as supportive. Essentially, all the recipes which involved some form of interaction with other people, whether professional or lay, could be seen as supportive. At least, there was always the potential for support to be given and received.

All the recipes and remedies given by the respondents carried the potential for 'support' within them. In an abstract sense it might well be argued that finding and enjoying a distraction, such as swimming, even if carried out alone, could be experienced as supportive. A sense of support might well be derived from relaxation exercises and meditation, or simply by adopting a more positive mental attitude. There is no suggestion here as to how long any of these remedies worked. I shall address that later. Those respondents who spoke about their dreams, hopes and fantasies implied that these things were uplifting and, by implication, supportive.

'Support' for these respondents had many meanings, but there were several common denominators. First, support implied a positive experience. Secondly, there was the element of being uplifted by someone or something. Thirdly, the word carried connotations about the person's emotional state and was linked to self-esteem. A supportive experience enhanced the respondent's sense of self and their social functioning. Earlier comments by respondents about 'being accepted' by a confidant, even when they were a 'bloody drag', and being helped through 'thick and thin' indicate that the respondents valued support and found positive benefits which flowed from it. The notion of support was part of the social cement which made the process of empowerment possible for these respondents. In the final chapter 'Unravelling the Issues' I shall draw together the threads of the respondents' experiences of empowerment.

Impaired Social Functioning - Remedies and consequences

A previous chapter addressed respondents' accounts of a sense of impaired social functioning in at least one of the areas of work, relationships or social conditions. This chapter has uncovered the resourcefulness of all those respondents. They all had some notion of non-medical treatment, if only in the language of known 'recipes' or remedies. These recipes were used in some cases as a reaction of despair, in others as a carefully considered form of treatment. Whatever the nature of the response, such treatment was aimed at overcoming a sense of impairment.

Without exception, the common theme which emerged related to a link between feeling low and a desire, whether conscious or otherwise of wanting to alleviate such lowness. I have isolated the concept of support as providing coherence in the respondents' otherwise diverse accounts. Talking was valuable because it was 'supportive'. Food and alcohol were temporarily supportive in several ways. Isolation following retirement could only be alleviated through the replacement of one form of support with another, and so on.

Intuitively, respondents sought alleviation from their depression. Often, it was much more conscious than that. While it is fair to say that, under 'normal' conditions (for instance, when one consults a doctor) people who seek a remedy

usually want to know how soon it will take effect, it was not the case with these respondents. They did not conceptualise the remedies in this conventional way. Theirs were 'trial-and-error' remedies. What had worked before was likely to work again, and that which had not worked was discarded.

However, there was recognition by many respondents that their remedies were not an ever-lasting panacea. They knew that the 'dose' or activity had to be repeated, as its effects would wear off after hours, days or weeks. The duration of the effect of any remedy varied with the respondent. There was some suggestion that the effect also differed depending on the activity. Re-ordering thoughts appeared to last longer than the 'quick fix' remedy of eating a box of chocolates.

No respondent made the extravagant claim that any remedy had produced a total recovery from their sense of depression. However, there were many claims of the benefits of certain remedies in providing alleviation, and considerable improvement in their sense of impairment. Self-prescribed remedies were also perceived as advantageous in that they prevented things from getting worse. Even if there was no dramatic improvement, the depression did not worsen.

The 80 respondents had as many stories on the vexed question of the duration of effect and long-term benefits of different remedies. Sometimes, only a 'quick fix' remedy was used, often two or more remedies were applied, one of which might be expected to give temporary relief and another which it was hoped would have longer lasting effect. Tricia, a 36 year old widowed woman with a history of asthma, explained:,

> I've got two problems in my life....no relationship to speak about and an awful one with a colleague at work. I'm working on finding a bit of romance, but really I go to the gym to get fit....no, let's face it - I go so I can look good - which gives a girl some confidence! The problem at work has occupied a lot of my thinking time, and what should have been sleeping time! I think I've figured it out - how to handle this colleague who's bugging me.

Tricia revealed her pursuit of an activity such as going to the gym as being helpful in keeping her buoyant and 'feeling good' even in the face of 'no romance'. She was addressing the work-related problem. She hoped that her efforts in that

regard would have a more enduring, if not permanent effect. She was re-ordering her thoughts in the hope that benefits would flow and she would gain improvement in her relationship with her colleague and thereby help alleviate her sense of impairment.

A problem for both non-medical professionals and depressed respondents alike related to their overwhelming reliance on individualistic remedies. As suggested earlier, this focus on individuals is socially sanctioned, culturally and professionally encouraged. In the face of social issues which presented as problems for many respondents, however, such individualistic remedies often miss the mark. Structural problems persist and for many respondents were major contributors to depression, yet is was difficult to address their sense of social impairment hence their reliance on individual strategies. However, the professionals, medical and non-medical alike, should be more aware of the link between private problems and public issues and should address that connection. This is where the application of what has been referred to in other papers, as a 'social health perspective' would be appropriate and timely (Bywaters 1986; Mullaly, 1988). Bywaters (1986) argues for a 'social model of health' which would require health professionals to examine both the 'social and personal context of ill-health.' By 'social health perspective' I mean that health professionals, medical and non-medical alike, should examine the relationships between 'social class and morbidity, between health and welfare and between social problems and manifestation of depression in an individual.'

However, the purpose of this chapter was to give the overall picture of non-medical treatment alternatives from the perspective of the respondents. Their consultations with both professional and lay people who they trusted and in whom they could place their confidence about their depression were considered helpful. Individually initiated activities, the recipes or remedies, were identified as enabling the respondents to feel that they were exercising some control and 'doing something rather than nothing'. While some of these remedies may only have short-term effects, the respondents felt encouraged by pursuing them. If depressed people are to be encouraged to achieve small victories, to cherish hopes and to make some plans, then all remedies which prove helpful, if only in the short-term should be supported. This sentiment is epitomised by one respondent who said, 'you have to have dreams and hopes, otherwise you'd go under'.

The continuum from formal to informal sources of non-medical treatment can be traced by several points. 'Counselling' and 'empowerment' emerge as overlapping yet distinct. Counselling often referred to 're-ordering thoughts' and 'developing hopes', and empowerment seemed to be summarised in terms such as 'achievement', 'enlightenment' and 'alleviating impairment'. Developing hopes might be a first step in the process of empowerment. The sustaining of these hopes was a continuation of a process which had just begun.

PART V

COHERENCE

CHAPTER 13

UNRAVELLING THE ISSUES

This chapter makes a social statement, about lives and life-styles and about a model of 'treatment'. This model includes social issues and the improved performance of roles, in context and as described by the 80 respondents.

Depression is a term widely used to describe a debilitating emotional condition. Different theories are promoted regarding the causes and treatment for this condition. For their part, the sufferers of depression, be they labelled 'patients' or 'clients', also have their views as to what depression means, how they cope with it and what helps them to get better.

The disciplines of psychiatry, psychology and sociology promote their own models of explanation of the causes of depression and the means of treatment. Although there is some overlap between them, these perspectives can be easily distinguished. Psychiatry has been concerned with certainties regarding the bio-medical and genetic predisposition to depression. This perspective has made it unlikely that psychiatrists would pursue research into social context. Much of the psychiatric research and literature talks about depression as if it occurs in a social vacuum.

Psychologists' interests in depression have ranged from a commitment to behaviourism by some researchers and practitioners to the adoption of psychoanalytic perspective by others, and an enthusiastic advocacy of the cognitive approach of Beck, by others. Whatever the particular psychological orientation, the nature of the language used makes it difficult to include considerations of context. A depressed person may not live in a social vacuum, but for the psychological researchers and practitioners, the context is a taken-for-granted backdrop which, even if it might be regarded as important, is not explored in any detail.

Sociological research and thought appear to pay attention to social context, but have little to say about treatment. Sociologists have given us valuable insights into vulnerability and biography, the thorny area of gender differences and the associations between unemployment and depression. The work of Brown and his colleagues has been especially valuable. However, sociological theory about the treatment of depression is, at best, implicit, and seldom explicit.

Before any 'treatment' can be offered, the issue of assessment of a condition such as depression needs to be addressed. Conventional 'clinical' scales such as the Zung self-rating depression scale used in this study, address the extent of an individual's depression. It is a useful tool, as far as it goes. Therein lies its problem. It does not attempt to explore social aspects of depression, as in making connections between scores on a scale and the life styles and life chances of the individuals concerned.

Corney and Clare, who condensed and refined from previous prototypes a self-rating social problems questionnaire, said, '... the questions in the SPQ (Social Problems Questionnaire) are mainly concerned with obtaining a reasonable estimate of the respondent's social and personal satisfaction' (1985: 638).

This 'Questionnaire' was used, in this Sydney study, to assess the social and personal circumstances of each respondent's life. The areas covered by the SPQ include housing conditions, occupation, finance, marital functioning, leisure and social activities, contacts with relatives, friends and neighbours, child/parent interaction and legal matters. The Corney and Clare SPQ assesses the situation of people in context.

In this study, despite the individual and combined merits of these two instruments, a third instrument, a revised Brown and Harris Schedule of Life Events and Difficulties, was also used. This latter instrument allowed me to delve into more detail and thereby obtain a richer picture of the constraints and opportunities in people's lives. Filling in self-report scales is one matter, and an important tool, but the researcher sitting with the respondent for up to two hours in a respondent's home is another. This more time-consuming activity reaped several rewards. First, it conveyed to the respondent that they were being taken

seriously and that their stories mattered. Secondly, it allowed the respondents to tell their stories more fully, and in their own words. Thirdly, it enabled the researcher to take in, both visually and emotionally, what it was like for the respondent living in their particular social context; and it helped me to perceive how depression might be affected by such context.

The use of these three research instruments maximised the opportunity to get a picture of depression, not only as an individual illness, but also as a social statement about lives and life-styles. That is, a fuller assessment of the respondent's depression was gained by using schedules and scales in combination. An assessment which uses a single measure in isolation is bound to miss features of an individual's life which may contribute to their sense of impaired social functioning.

The interviews and the inventories brought this researcher face-to-face with the interrelationship between individuals and social conditions. From the respondents' accounts, it was clear that any assessment or treatment of depression involves other people, including medical and non-medical professionals. A variety of perspectives can be brought to bear. However, it was also obvious that issues concerning social and economic policies, rarely mentioned in research or by practitioners, require much greater attention. Depressed respondents, like the rest of a community, live under particular social, economic and political pressures, constraints and opportunities. To ignore these conditions was to take a myopic view. Even if we accept the tenet that depression is genetically determined, the depressed person's social context could still be important in contributing to or alleviating the predetermined tendency. Whether someone has been retrenched, is unemployed, dissatisfied with work, unable to meet the bills or stuck at home with three toddlers under five are central considerations of social context. So too are the government's social and economic policies and their impact on certain groups of vulnerable people. A person who has been recently retrenched and is forced to wait and qualify for unemployment benefits is, arguably, more likely to feel a sense of powerlessness and depression than a person who has been retrenched but can salvage some economic and emotional self-esteem by immediately receiving generous redundancy payments.

Women and Men, Migrants and Non-migrants

Other ways of addressing questions of context involved some appraisal of taken-for-granted assumptions. Are women more vulnerable to depression than men? Are migrants more vulnerable than non-migrants?

Commonly held assumptions about the vulnerability of women seemed to be confirmed but it is important to put this observation into context. More women than men came forward to be involved in this study. This suggests confirmation of those research findings that women seek help more often than do men, that is, being a respondent in this study might well be considered as a form of 'help' or 'therapy'. Some respondents said as much.

Many of the women in this sample were vulnerable to conditions of social isolation, the stresses of caring for children on limited incomes and the strains of an unsatisfactory relationship. Some of the women found the combination of paid work and domestic duties stressful and depressing. The depression of others was related to frustration about being housebound and feeling insignificant. This feeling of powerlessness and lowered self-esteem was epitomised by a young woman who had been employed prior to her responsibility for the care of small children at home. She said: 'I hated having to retire back to soap operas and talk back shows'.

Over the years, researchers have argued the point about whether gender differences in the incidence of depression are real or an artefact. In this study, it was evident that there were differences between the sexes in terms of their concern within their social context. No conclusions can be drawn about incidence per se, but there were differences in perception about roles in context. Such perceptions lead to some specific observations, on my part, about context and the process of empowerment in relation to women, men, migrants and non-migrants.

For many of the men, their notions of self-esteem and integrity were tied closely to their role as worker in the paid workforce. An unexpected change in that role produced a sense of vulnerability, a feeling of powerlessness at the

prospect of long-term unemployment. A disabled man in his early forties said, 'I am on the scrap heap of life ... The best thing to hope for is not to live that long'.

In their need to overcome such a sense of impairment, the men seemed to differ from the women when it came to the form of solace they sought. The contrasting uses of food and alcohol are one example of such differences. To console themselves men appeared to use alcohol and women food. Typical of this pattern were the male and female respondents who respectively commented: 'I turned to drink to blot our my misery' and 'I've found that I can eat my way out of my depression'.

For the migrant respondents, there were some different concerns about social context when compared to the non-migrant group. In the case of the migrants, there was a distinct sense of loss. A loss of identity, country and context. They faced unemployment and underemployment. They faced discrimination and sometimes, overt racism. One migrant man explained: 'We only get dirty jobs even if we are qualified, and get called bad names'.

They experienced a sense of loss from their own country and customs. Some migrants found a cultural clash in terms of ideas and values. As one migrant put it, 'There are no strong values in this culture, only 'she'll be right' and other expressions of indifference. That is not a solid base to build on'.

A major difference between migrant and non-migrant respondents concerned their perception of the nature of social support. Many of the migrant respondents spoke of the tremendous benefit they derived from collective sources of support, such as discussion in social groups within their own ethnic community - compatriot group. For many of the non-migrant respondents, a sense of social support came more through a strong relationship with one key person, whom they felt they could trust, respect and confide in. Many spoke about a sense of reciprocity, that is, a sense of recognition coming from a relationship with such a confidant.

However, whether the respondent was male or female, migrant or non-migrant, some common principles apply regarding 'assessment' and 'treatment'.

These two words may sound overly clinical at first glance, but they can be used in a way which uncovers social meaning and social context. Such uncovering seems likely to be of particular value for people who are depressed and who have met with counsellors or doctors who, for a variety of reasons, paid no attention to social issues.

The Assessment/Treatment Conundrum

The respondents' accounts of the remedies they used to combat depression suggest that assessment and treatment of depression are interdependent. For example, some respondents spoke of the benefits to be derived not only by discussing feelings but also matters of social context. Yet the question how to formulate ideas about social context which could uncover conditions contributing to depression and point to strategies which could affect recovery, was a conundrum. For the possible benefit of future researchers and prospective helpers, the resolution of this conundrum in this study was captured in the notion of impaired social functioning (ISF). This ISF typology, which, at first sight might appear a clumsy concoction, should enable researchers and practitioners to pose questions and piece together a picture of contributing and alleviating conditions in the areas of work, relationships and social environment.

The social context of people's lives is caught within that typology. It pays attention to roles and vulnerability as they manifest themselves in key areas of people's lives. The ISF typology was foreshadowed by respondents' own evaluations of their thoughts, feelings and behaviour: 'I was so depressed I stopped functioning', 'I bottomed out and found it hard to function', and 'I had an overwhelming feeling of hopelessness and was not motivated to do anything'. Responses to the Zung Self-rating scale foreshadowed the notion of impaired social functioning. For instance, 42% of all respondents said they were not finding it easy to do the things they used to and 38% said that 'only a little of the time' did they find it easy to make decisions.

In each of the areas of work, relationships and social conditions, respondents spoke of experiences which contributed to or alleviated their depression. The combination of contributing and alleviating conditions produced a

sense of impaired social functioning. In summary, impairment in the world of work concerned three issues including references to the lack of 'work'. First, some work was perceived to be unrewarding, in its routine nature, or lacking in demands or career prospects. Secondly, some work was experienced as demeaning, either because of the low pay or the feeling of not being valued. Thirdly, enforced retirement and unemployment produced a sense of powerlessness in the face of no other productive activity.

With regard to relationships, impairment was related to three concerns. In the first instance, there was a sense of loss and isolation, in the lives of those who had not succeeded in 'pairing off'. A second issue concerned covert and overt conflict in relationships, which led to a sense of dissatisfaction. Lastly, some respondents were concerned with issues of identity, involving their perceived failure to realise a certain status: having a satisfying relationship with a partner; fulfilling a role as a parent.

In the area of social conditions, respondents' comments reflected three issues. Firstly, there was dissatisfaction over lack of material resources, even to the point of concern over meeting mortgage repayments or the weekly rent. Coupled with this was the concern of those who felt they had no choice as to where and how they lived. Secondly, there was dismay over government policies which were perceived as undermining occupations such as teaching, or in making citizens more financially vulnerable. This latter is a reference to points of view about harsh taxation law policies and practices and perceptions of the Federal Government's disinterest in maintaining universal health insurance i.e. Medicare. Thirdly, there were issues concerning standards of accommodation, plus anxiety about the maintenance and upkeep of one's physical surroundings. Paradoxically, there were respondents who felt cramped and depressed because of their oppressive accommodation and others, mainly elderly people, who were nervous about living in large, unmanageable homes.

The ISF typology demonstrated the difficulties which the 80 respondents encountered in the context of living in inner Western Sydney in the late 1980's. Their problems reflected those concerns and produced in the people concerned, a

feeling of lack of control. This 'lack of control' appeared linked to their vulnerability to depression.

This ISF typology can be linked to the process of empowerment. For example, the changes from a 'lack of control' to 'regaining control' could refer both to improved role performance, that is less sense of impairment, and to some steps of empowerment.

This typology provides a convenient way of structuring and organising information in any assessment of depression. To be able to spend two or three hours in the respondent's home, to gather data and to arrive at an 'assessment' which could be used as a foundation for any treatment offered was a privilege for me as the researcher. For many depressed people, however, the doctor is the first port of call. The conditions under which doctors work, even by their own admission, do not allow them the time to pay close attention to the patient. Consequently, many depressed patients reported that they did not feel the doctor took them seriously. There was precious little time, and sometimes a dearth of knowledge, to enable a doctor to pay attention to social issues: to explore how patients felt about themselves and their work and how they perceived their future.

Although some depressed people said they felt comfortable in going to a doctor's surgery to complain about feeling low, feeling tired or lacking control, there were also those who were reluctant to do so, for a variety of reasons. Both the group who were willing to attend a doctor's surgery and the group who were not, had in common the notion of the perceived usefulness of the doctor. They held a taken-for-granted assumption both about the availability of doctors and about the benefits of visiting them. In this country, cultural perceptions and the accessibility of a healthcare system made it easier for a depressed person to find a doctor than to find a non-medical professional. Notwithstanding these considerations, the respondents spoke candidly regarding their perceptions of medical intervention. While drug treatment was welcomed by a small minority, many respondents were adamant that they did not want to 'walk around in a foggy state', nor did they want to feel 'a slave' and by implication, powerless, to medication.

The discussion of contributing and allieviating conditions will be developed in my conceptualisation of a continuum from counselling to empowerment. In similar vein the ISF typology could be valuable in making the link between individual problems and social issues. It could be regarded not only as a useful diagnostic tool but also as a means of developing ideas about empowerment.

The 'Non-Medical Alternatives'

An almost infinite list of non-medical treatment alternatives was identified by the respondents. Most respondents had no difficulty in naming more than one 'recipe' or strategy which they found useful. However, even in the identification of non-medical treatment alternatives, most of the remedies did not pay attention to roles in context. Both the depressed respondents and helpers tended to talk about individual remedies. In spite of the rich variety of actions and activities construed as non-medical treatment alternatives, neither the respondents nor the helpers picked up on the issue of impaired social functioning. That is to say, although the respondents spoke of 'not coping' and 'functioning below par' their remedies were more related to lifting low moods, making them feel better, often in a 'quick fix' manner. An illustration of this was given by a woman who felt she was not coping, financially or emotionally and was having difficulty with pressures at work, yet her remedies related to food. Her experience of difficulties in relationships and at work and the struggle to meet the rent was addressed by 'eating my way out of trouble'.

There was not much correspondence between non-medical treatment alternatives on the one hand, and those other factors which gave social meaning to their lives: experiences of work, relationships and social conditions. This irony is illustrated in the chapters No Relief In Sight, Highly Vulnerable and Not So Vulnerable. There exists a disparity between what the respondents talked about as contributing to and alleviating their sense of impairment and the non-medical treatment alternatives they cited as having used.

The handing down of traditional remedies or 'recipes' for depression among lay people appeared to have as much influence as the repetition of medical remedies advocated by professionals. Both lay and professional groups had their

own models of explanation and forms of treatment. There was a taken-for-granted tradition, almost a momentum behind both sets of remedies, medical and non-medical alike.

Yet, both respondents and different practitioners, even if they were not explicit about it, saw the importance of taking social context into account in any assessment and treatment of depression. In order to make the significance of social context more explicit, there has to be a shift in language, so that almost anyone, professional and non-professional alike can feel comfortable in talking about their vulnerabilities, in context and over time. In this respect, the notion of impaired social functioning can be applied to facilitate analysis of people's responses. The ideas and issues embodied in the ISF typology can be developed into a perspective on 'treatment' in which empowerment is a central theme.

For example, this study found that in terms of individuals' explanations, personal and contextual issues were inseparable. Relationship problems were linked to feelings of not being able to go out socially, or to feelings of isolation. In addition, there were problems associated with the peculiar problems inherent in surviving in an impersonal, urban environment in contemporary Australia: being widowed, divorced or unemployed, or feeling 'unwanted' because of ethnic background. These are forms of social vulnerability which have an impact upon individuals. A common denominator in these examples is a need to exert control over life and life-style. In this respect, the severely depressed respondents in this sample were people who appeared never to have had much control over their lives and life-styles or, even having attained control, had lost it.

The notion of 'control' is central to the empowerment process. A similar point was made by Holland (1991) who examined the meaning of 'prevention' in regard to the activities of mental health practitioners. In discussing the lesson learned from an experiment with prevention in a community mental health centre, Holland wrote, '... the field of preventive work in mental health must take as its central task the transformation of passive receivers of mental health services into active participants in the understanding and the solutions to their own and their neighbours' mental distress' (1991: 131). Such emphasis on the change from

passive receivers to active participants is germane to my own account of empowerment.

The key common denominators in their experience and in their reactions to them could be regarded as 'political' in the following sense: (a) the domestic context of depression was linked to wider policy developments or political initiatives such as those which affect migration and employment; (b) a sense of despair was related to the political dimensions of Australian culture, such as the current tensions between notions of welfare and the 'user pays' philosophy and the perceived 'unfair' nature of taxation and social security policies. For some people depression was perceived as reflecting, at least in part, the consequences of various policies, that is, arising from political developments. Any consideration of appropriate responses to such a condition should reflect such an interpretation. For some people, especially those living on or near the margins of poverty, the worsening nature of the Australian economy in the late 1980's and early 1990's had the effect of their individual depression being intertwined with that wider scale economic recession. As the recession set in, such vulnerable individuals were being entreated by a Labor Government to 'tighten their belts'. However, in their case, they had already reached the last notch. The continuing, and worsening economic climate meant stretching already stretched-to-breaking point budgets. Pay fell behind rising prices. Some respondents experienced retrenchment and enforced early retirement.

'Education' or 'Treatment'

Putting all these denominators and considerations together leads to the contention that even the notion of 'treatment', with all its medical and clinical overload may be inappropriate. Instead of treatment, what many respondents appeared to be asking for was an educational experience through which they could begin to feel a greater element of understanding, and thereby some feelings of control over their lives.

The notion 'treatment' is too restrictive. It connotes assumptions about experts, expertise and the persistence of a power imbalance between 'helper' and 'helped'.

In what ways might the educational implications of working with people with depression be developed? In what ways might traditional forms of help, such as counselling, contribute to an educational experience in which the person with depression feels directly involved?

At the face-to-face level, counselling techniques were identified as a valuable form of 'education' for the depressed person. Some respondents found listening and talking helpful, but only if they were taken seriously and their revelations treated in confidence. Material and practical help was always welcome. Depending on how it was given, advice was palatable and could be useful. These responses had educational implications if they were also a means of discussing relevant social issues, as when a depressed person realised that they were not alone, or realized that association with others could return to them some measure of control over their life. Counselling dealt with individual issues and addressed a sense of powerlessness. It could be regarded as a prerequisite for those early stages in the process of empowerment.

With reference to the structural constraints on people's lives, remedies in relating to social and economic policy issues required action at a level removed from one-to-one interaction. Nevertheless, respondents should be helped to understand that problems associated with unemployment, housing, low pay or worker's compensation can be addressed at a level of government policy, and are not matters of individual shortcomings or failure. Empowerment addresses the social, political, economic and cultural issues which were raised initially in those exchanges described as counselling.

In this study, there was a relationship between a high risk of depression (as indicated on the Zung Self-Rating Depression scale) and a high incidence of social problems. For instance, in the .80 percentile, there was an average of 11 problems referred to as 'marked' or 'severe'. But the small number of problems referred to by those in the .30 and .20 range were identified by those respondents as 'mild' and 'moderate'. The connotation of the word depression includes the impact of social and economic policies. It is a mistake to confine consideration of depression to physical and emotional symptoms. Assessment and treatment should take into account key areas of people's lives in which they might experience a sense of

impairment, as in discussion of expected role performances. There has to be a means of talking about these key areas of people's lives.

As contended earlier, 'treatment', for want of a better word, should pay attention to the need for 'education'. The depressed individual contributes to and shares in this process. Individually-initiated activities were reported to be helpful. Such small victories were important to each individual. They should be encouraged by professionals dealing with depressed people, albeit without losing sight of the wider social, economic and political issues which affect depressed people's lives.

Helping people with individual initiatives begins an educational process but it is important to move beyond such an individual focus. An introduction to the possibility of collective action as in helping people make links between private problems and public issues is a next step. Holland also developed a model which moved from the individual to the collective, as in her account of moving the depressed person from '... the individual Symptom, into Psychic Knowledge, into shared desire into social action' (1991: 131).

Private Problem or Public Issue?

Non-medical professionals and depressed respondents relied overwhelmingly on individualistic remedies, which are culturally and professionally encouraged. With reference to this last point, the typology of depression as impaired social functioning is a cue for the beginning of an educational process as well as a guide in assessment. The very language of 'people playing roles in different contexts' opens up relevant ways to consider social issues as well as individual problems. This point applies as much to the depressed person as to the prospective helper. The language of impaired social functioning introduces the idea of a balance of contributing and alleviating roles played in the contexts of work, relationships and social conditions. It thus produces a far wider repertoire of ideas and strategies than any reliance merely on individual models of explanation of behaviour. In this way, professionals, medical and non-medical alike, can explore the link between private problems and public issues.

While the social worker who suggested to the unemployed man that the problem resided within him may have been referring to the need for the man to take action to help himself, that professional's comment also seemed to imply either an ignorance of structural issues or an inability to address them in any helpful way. Unemployment, retrenchment and suspension from work through injury are experienced as individual problems, albeit with structural antecedents and consequences. Not to address these issues borders on professional negligence. There is a place for individually-initiated activities, but there would also be room for professional helpers to facilitate action through strategies which confront social and economic, that is, structural constraints.

Depressed people do not live in a vacuum and they are far from 'being alone' in their experience of depression. It is of central importance that any helping professional make this clear in meetings with the depressed person. By doing so, that depressed person is given encouragement to take some elements of control, to convert hopes into plans. The respondents in this study have spoken loudly and clearly. Some summarised their needs for control: 'you have to have dreams and hopes, otherwise you'd go under' and 'Life has to get better if only I could get out of here'. Such dreams and hopes symbolised ways out of the experience of depression. Depressed people craved understanding and thereby an increased sense of control. This desire to 'see the forest for the trees' can come through the lay or professional person paying attention to the language of the depressed person. This presupposes some sensitivity to context and the importance of the performance of roles.

The language used by most of the respondents suggested that they wanted to play a larger role in their own 'education' and 'treatment'. There is some value in doing something. That 'doing something' should be encouraged. In this respect, the notion of support, as in 'sharing' and 'not being alone' would be central in any shared educational plans. Such educational plans contribute to the process of empowerment, as in respondents' repeated references to their desire to work out ways to regain some control over their lives.

The Social Context of Depression

This Sydney study of depression aimed to examine the experiences of a heterogeneous sample of people and to do so by interviewing them in their own homes. Although the clinical criteria for assessing the extent of these respondents' depression were not to be ignored, a focus in this enquiry was the social context which, from each respondents' points of view, affected the onset and duration of their condition and the chances of recovery from it.

Even at the conclusion of this study, the notion 'social context' merits more specific description, otherwise it will seem unexceptional: always present yet having few distinguishing features. There is a sense in which the issues described in the previous pages, - of women and men, of migrants and non-migrants, the assessment/treatment conundrum and the 'non-medical treatment alternatives', - could all be considered reflections of the constraints of social context. Given their expectations of status through employment, men were vulnerable to depression through early retirement and unemployment. The expectations of some women in this sample were characterised by hopes of accomplishing a better balancing act: as between paid employment and family responsibilities. Other women suffered a sense of impairment because they were bored at home and longed to have the stimulation of outside employment. Others felt impaired because their gender sometimes dictated that they held demeaning and frustrating jobs and had little in the way of future prospects. Both women and men held hopes for satisfying relationships and comfortable homes.

The division of the tasks of assessment from those of treatment was a product of particular assumptions about medical practice and the ways of organising health and related services. Non-medical treatment alternatives seldom managed to embrace the social issues which respondents had described. Social/contextual issues were identified by all respondents in terms of constraints affecting their everyday lives, yet when it came to considerations of how to recover from depression, these issues appear to have been either ignored or addressed more by accident than by design.

In an attempt to ensure that in future the notion of social context becomes part of the theoretical orientation of researchers and practitioners who are examining the nature of depression and how to treat such a condition, four points will be made. I shall address each of those points briefly. They have already been discussed in the pages of the twelve previous chapters.

1. If the assessment of depression is to include issues of social context as a central consideration, several perspectives have to be explored. One set of problems, concerns the experiences of migration, employment, ill health and social isolation. The language to address these social issues has to become part of the stock in trade tools of practitioners of various descriptions and thereby of the people whom they seek to help.

2. The typology of depression as a manifestation of impaired social functioning addresses directly several issues of social context.

   The very terms which describe alleviating and contributing (the positive and negative) conditions with regard to daily experiences will enable respondents to feel that someone wishes to comprehend their living conditions and how those affect them. To talk a depressed person through their 'contributing' and 'alleviating' experiences in relation to different areas of their lives is to enable them to go through a sort of social check list. Indeed this was how the typology of impaired social functioning came to be sketched in the first place.

   At this point it may be said that the uses of this typology must remain hypothetical: they have yet to be tested in any experiment. Yet the use of these terms seems to have been indispensable in producing an account of depression which was grounded in the respondents' own narratives. They wanted the chances to develop those narratives and in so doing to participate in an educational experience if not a process of treatment.

3. The status of the medical profession and the ways of organising medical practice have made considerations of social context unlikely. Medical models of explanation of behaviour had few ways of putting issues of

unemployment, poverty, poor housing and social isolation centre stage. So they remained as peripheral concerns, even for those general practitioners who worked in areas with a high incidence of social problems.

There were two other ways in which medical practice limited the chances of social issues being addressed. General practitioners remained the first port of call for many respondents, but even if such doctors made referrals elsewhere, (that is, they did not try to treat the person themselves) they usually kept those referrals within medical networks. A second point concerns the fee for service means of doctors' remuneration. In Australia, general practice is organised as a business. Once a consultation went beyond about six to eight minutes, some doctors maintained that they were losing money. Yet the respondents felt that deliberations over matters of social context would take a great deal of time and patience.

There is a paradox inherent in these points about the practice of medicine and the organisation of health services. Such 'practice' and 'organisation' are matters of context, yet they precluded serious consideration of social contextual issues. Even the non-cooperation between the representatives of different occupations seemed an offshoot of medical dominance and the reluctance of people to work in teams, each member bringing their immediate perspectives to bear, not least those which unmasked the problems of an immediate locality.

4. Non-medical treatment alternatives presuppose discussion of social issues as well as individual ones, of the impact of social policies as well as consideration of an individual's personal resources. When 'treatment alternatives' become converted into 'educational experiences', the accounts of the depressed person and thereby perhaps their growing empowerment, become central pieces of the jig-saw for those who wanted to produce a shared plan for help and for change. The ideas are there in the rich variety of what these respondents described as their treatment remedies and in the colourful ways in which they gave their accounts.

Without those accounts, the social context will continue to be ignored and the complex mix of psychological, economic, social and political issues will find no place in official accounts of depression. Yet the connotation of the word 'depression' went beyond a classification concerned with the labels psychotic and neurotic, endogenous or reactive, vulnerable or coping. I only had to stay close and faithful to the respondents' narratives to be able to grasp the wide dimensions of that connotation. It took time to obtain those points of view. Yet the respondents, however disempowered by their experiences, wanted to be asked, wanted the chance to tell their stories and to fill out a picture of struggle to live. More specifically, it was a struggle to receive encouragement and obtain satisfaction, to regain a measure of control in the context of lives lived in some inner suburbs of a large Australian city in the late 1980's.

From Counselling to Empowerment

For non-medical helping professionals, there are benefits in reconceptualising depression in terms of the ISF typology. This typology promises a means by which to organise the often diverse complex 'data' which confront a practitioner and researcher. For example, if the concepts and content of the ISF typology are developed, this study can have implications for social work practice. First, the catch-all term 'counselling' can be defined more precisely. As a non-medical 'treatment' activity, counselling refers to work undertaken between the depressed person and a professional or lay person for the purpose of addressing individual difficulties of a social-emotional or interpersonal nature. The ingredients of such a relationship include trust, empathy and confidentiality. However, such counselling, almost by definition, precludes consideration of ways of resolving wider social issues, although the issues themselves may be discussed. Nevertheless, counselling may be considered to be an important first step towards the development of empowerment. At least in the individually-initiated activities of counselling, the depressed person's sense of powerlessness is addressed. An important beginning.

Secondly, social work practitioners should be alerted to the proposition that counselling in relation to depression is useful with regard to the provision of that

support and those ingredients which prepare the respondent for the empowerment process which follows. Thirdly, such practitioners should keep in mind that empowerment would take up the language of ISF by enabling each respondent and client to examine systematically the implications of impaired role performance in different areas.

The empowerment process which follows would require the practitioner and depressed client to move through various steps. The first of these include the steps of understanding themes, evaluating self-image and knowledge of specific problems. Rees (1991:89) describes these steps as amounting to a 'stage' of education and awareness. According to Rees, part of any such goal of education and awareness is to enable the client to understand that their predicament of powerlessness is partly grounded in social issues, including the consequences of economic policies. In his words, 'Discussing how policies and services affect people has two effects. There is the obvious outcome of enabling them to know that services and other resources exist to which they are entitled. Secondly, the act of demystifying what policy is about becomes part of an overall educational and political process' (Rees, 1991:93).

A second general stage in the empowerment process refers to people participating in dialogue and experiencing solidarity. In Holland's view this process, which she calls 'shared desire' is crucial in any attempt to involve depressed people in the solution of their problems. Social workers should be familiar with such claims. They have recognised the benefits of support groups and support networks and have worked to develop such resources. In this respect, Rees contends that bringing people together who share the same predicament can be a means of education '... because it reveals a common grievance and encourages a sharing of ways to respond to such problems' (1991:94).

Even in social work with people suffering from depression, the political dimension is important. 'Political' refers to the exercise of power, as in the impact on people's lives of those structures and institutions which produce and sustain massive social inequalities. For example, Usher (1988) pointed out that support groups which do not discuss how political processes maintain social arrangements, only confirm the class-related myths about the psychological reasons behind

individual feelings of powerlessness. In a similar vein, Holland, in her advocacy of prevention of mental health problems and the need for people to be involved in their own recovery from such difficulties, asserted that if these people are not to remain victims then they must recognise the '... British welfare state's attempt to treat, administer, therapeutise, tranquillise and neutralise them out of their justifiable rage' (1991:135).

A third stage in the empowerment process for a depressed individual involves the recasting of their sense of identity. The non-medical professional working from an empowerment model can enable the client to rework and redefine their sense of self in relation to others. As Stuart Sutherland (1987) discovered during his own long experience of depression, that condition can have battering effects. The depressed person is likely to suffer from low self-esteem and little sense of the worth of life. One respondent in this study called such experiences 'an ego battering'. Part of any process which can be justifiably labelled empowerment must recognise the real need to help rebuild and redefine the 'battered' sense of self which the depressed person carries around with them.

A final step in this empowerment process involves action. Action stems from the preceding steps. Once awareness is achieved, solidarity and dialogue developed, and the depressed person's sense of self strengthened, that person is in a position to make some choices and act on their own behalf. Often, depression is an immobilising condition, and it is not until the person feels sufficiently encouraged to take action to improve their lot that empowerment begins to be achieved. Such 'action' can include membership of recreational groups, educational programs and team sports. It can also include letter writing, keeping diaries and offering support to others.

This counselling/empowerment model should be conceived as involving an educational process rather than another set of procedures for clinically oriented treatment. Empowerment through education would involve a depressed person and a variety of lay and professional associates in a process of mutual problem solving in which the stimulation of new ideas and activities gives energy and character to the enterprise. This may not be easy because of the tendency for depressed people to avoid talking openly about their condition. Yet, depression

and its intimate connection with sadness, misery and despair is a dreadful burden to carry alone. Nairne and Smith claimed, 'There is enormous pressure on all of us to be happy or at least to pretend to be; to keep miserable or worthless feelings quite separate from the rest of our lives. Even among out closest friends, it can be very difficult to share our morose thoughts. It is not really polite to discuss your suicide fantasies, or your most depairing point of view' (1985:172).

Respondents in this study confirmed the burden of carrying their depression alone. They often felt rejected by medical and non-medical professionals. Sometimes not even friends or family seemed to understand or even to want to understand.

The effects of rejection and the experiences of lack of understanding could be nullified even if some of the implications from this study were followed. For example, non-medical practitioners, in particular those who work in health care settings could and should become familiar with the theory and techniques of empowerment. Such professionals may continue to practice counselling but it is salutary to remind them that from the point of view of respondents in this study, such counselling often served to mask social issues rather than confront them. Yet, counselling could contribute towards empowerment if several procedures were implemented.

First, the use of a specific language, as in ideas about depression as impaired social functioning (that is, the use of the ISF typology) could ensure that matters of social content would be quickly addressed. Second, the appraisal of each person's life events in terms of general themes as well as specific problems should be seen very explicitly as the beginning of a shared process of education. Third, the dialogue about depression in relation to policy issues as well as individual expressions of powerlessness has the potential to contribute to political understanding and skills: the depressed persons are no longer left to blame themselves. Finally, a goal of empowerment is reached when individuals, albeit in association with others, take action, mark the improvement in their feelings and circumstances by some small achievements and begin to re-cast their own sense of identity.

When these procedures are followed, the concept 'non-medical treatment' would be replaced by the idea of empowerment as a process of mutual education. In that way a variety of professionals and lay people, and in particular social workers, would be able to confront those aspects of the social context of depression which have been highlighted by the heterogeneous sample of Australian citizens whose hopes and fears, constraints and opportunities have been the subject of this study.

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APPENDIX 1

1981 CENSUS DETAILS

Birthplace
by Local Government Areas
in Sydney Statistical Division

Local Government Area	AUSTRALIA	AUSTRIA	CANADA	CHILE	CHINA
Ashfield (M) LLGA	22,382	61	40	205	578
Auburn (M) LLGA	27,141	65	28	294	783
Bankstown (C) LLGA	109,653	262	94	352	519
Baulkham Hills (S) LLGA	82,161	167	187	94	437
Blacktown (C) LLGA	143,260	343	143	414	464
Blue Mountains (C) LLGA	51,501	129	117	8	75
Botany (M) LLGA	18,525	39	34	676	231
Burwood (M) LLGA	16,599	50	45	122	605
Camden (M) LLGA	15,543	25	14	5	45
Campbelltown (C) LLGA	94,005	198	116	573	133
Canterbury (M) LLGA	74,201	160	84	371	1,205
Concord (M) LLGA	15,930	32	26	47	286
Drummoyne (M) LLGA	21,156	47	45	32	110
Fairfield (C) LLGA	80,602	418	95	2,329	2,395
Gosford (C) LLGA	94,050	86	121	16	134
Hawkesbury (S) LLGA	36,597	54	40	6	51
Holroyd (M) LLGA	57,233	116	45	206	270
Hornsby (S) LLGA	92,577	172	259	129	496
Hunter's Hill (M) LLGA	9,302	63	53	22	49
Hurstville (M) LLGA	49,179	65	60	83	520
Kogarah (M) LLGA	34,160	71	66	94	243
Ku-ring-gai (M) LLGA	75,463	259	449	115	673
Lane Cove (M) LLGA	20,523	78	76	39	156
Leichhardt (M) LLGA	37,980	102	141	104	246
Liverpool (C) LLGA	67,491	209	66	554	315
Manly (M) LLGA	25,465	58	158	45	97
Marrickville (M) LLGA	41,320	115	79	283	704
Mosman (M) LLGA	18,651	57	127	34	86
North Sydney (M) LLGA	31,990	143	249	72	256
Parramatta (C) LLGA	95,675	172	152	419	669
Penrith (C) LLGA	103,669	253	124	101	187
Randwick (M) LLGA	74,676	281	191	528	809
Rockdale (M) LLGA	54,000	100	76	188	788
Ryde (M) LLGA	63,588	105	154	261	747
Strathfield (M) LLGA	16,524	55	42	95	546
Sutherland (S) LLGA	145,801	264	244	106	304
Sydney (C) LLGA	46,992	218	316	288	1,046
Warringah (S) LLGA	131,676	261	521	181	463
Waverley (M) LLGA	34,522	395	171	151	313
Willoughby (M) LLGA	34,837	156	174	47	528
Wollondilly (S) LLGA	20,781	40	15	7	12
Woollahra (M) LLGA	31,776	371	228	43	182
Wyong (S) LLGA	72,040	45	75	7	80
TOTAL SYDNEY (SD)	2,391,197	6,360	5,540	9,746	18,836

Local Government Area	CYPRUS	CZECHO-SLOVAKIA	EGYPT	ENGLAND (INCL U.K. UNDEFINED)	FRANCE	GERMANY
Ashfield (M) LLGA	118	118	194	1,286	81	230
Auburn (M) LLGA	174	84	170	1,187	30	176
Bankstown (C) LLGA	762	202	763	5,217	113	1,173
Baulkham Hills (S) LLGA	98	111	240	5,896	61	786
Blacktown (C) LLGA	511	326	959	10,292	190	1,676
Blue Mountains (C) LLGA	20	117	48	5,284	67	589
Botany (M) LLGA	421	155	1,082	1,073	39	142
Burwood (M) LLGA	141	49	195	881	48	163
Camden (M) LLGA	18	16	9	1,260	7	156
Campbelltown (C) LLGA	85	140	196	9,205	101	944
Canterbury (M) LLGA	1,380	185	1,310	3,265	141	504
Concord (M) LLGA	102	33	112	730	15	107
Drummoyne (M) LLGA	90	28	186	1,138	30	115
Fairfield (C) LLGA	260	339	555	4,659	199	1,535
Gosford (C) LLGA	18	56	78	6,597	50	425
Hawkesbury (S) LLGA	17	31	27	2,550	30	342
Holroyd (M) LLGA	181	107	280	3,165	69	453
Hornsby (S) LLGA	43	163	168	7,760	116	765
Hunter's Hill (M) LLGA	28	45	54	663	12	95
Hurstville (M) LLGA	223	71	466	2,480	36	243
Kogarah (M) LLGA	214	70	335	2,050	42	218
Ku-ring-gai (M) LLGA	33	237	172	6,401	153	792
Lane Cove (M) LLGA	24	114	141	1,988	65	230
Leichhardt (M) LLGA	137	95	181	3,269	118	369
Liverpool (C) LLGA	244	199	295	4,366	89	903
Manly (M) LLGA	49	38	90	3,233	104	233
Marrickville (M) LLGA	572	113	811	2,046	132	385
Mosman (M) LLGA	30	42	56	2,203	83	199
North Sydney (M) LLGA	33	158	173	4,358	193	467
Parramatta (C) LLGA	216	232	433	6,227	101	787
Penrith (C) LLGA	253	157	310	10,500	104	1,342
Randwick (M) LLGA	550	344	1,242	5,779	263	851
Rockdale (M) LLGA	569	121	1,016	3,272	81	347
Ryde (M) LLGA	180	246	317	4,187	89	490
Strathfield (M) LLGA	88	49	177	723	39	160
Sutherland (S) LLGA	178	141	571	9,774	92	1,100
Sydney (C) LLGA	288	272	306	5,047	322	766
Warringah (S) LLGA	61	222	330	14,439	265	1,325
Waverley (M) LLGA	77	598	312	4,031	283	792
Willoughby (M) LLGA	39	166	235	2,924	131	341
Wollondilly (S) LLGA	6	26	13	1,768	17	195
Woollahra (M) LLGA	48	391	212	3,508	372	653
Wyong (S) LLGA	16	32	90	4,204	36	352
TOTAL SYDNEY (SD)	8,595	6,439	14,910	180,885	4,609	23,916

Local Government Area	GREECE	ITALY	LATVIA	HONG KONG	HUNGARY
Ashfield (M) LLGA	805	3,325	41	527	175
Auburn (M) LLGA	429	677	62	173	85
Bankstown (C) LLGA	2,365	2,922	478	307	312
Baulkham Hills (S) LLGA	287	1,332	77	477	178
Blacktown (C) LLGA	969	2,228	109	331	500
Blue Mountains (C) LLGA	92	148	56	58	131
Botany (M) LLGA	1,516	757	7	248	106
Burwood (M) LLGA	672	1,739	34	381	116
Camden (M) LLGA	40	307	2	15	15
Campbelltown (C) LLGA	260	603	30	109	166
Canterbury (M) LLGA	7,212	3,877	64	921	330
Concord (M) LLGA	486	1,842	34	174	71
Drummoyne (M) LLGA	651	3,241	10	126	79
Fairfield (C) LLGA	590	6,749	138	322	358
Gosford (C) LLGA	99	233	35	61	56
Hawkesbury (S) LLGA	105	203	28	32	49
Holroyd (M) LLGA	715	1,617	72	132	138
Hornsby (S) LLGA	161	1,011	148	620	189
Hunter's Hill (M) LLGA	105	219	11	42	86
Hurstville (M) LLGA	1,143	1,015	37	387	87
Kogarah (M) LLGA	1,259	782	39	360	87
Ku-ring-gai (M) LLGA	185	521	83	856	376
Lane Cove (M) LLGA	121	283	21	199	156
Leichhardt (M) LLGA	757	2,246	54	191	175
Liverpool (C) LLGA	628	3,168	42	119	191
Manly (M) LLGA	167	236	19	146	46
Marrickville (M) LLGA	6,033	1,651	32	449	279
Mosman (M) LLGA	94	146	9	71	95
North Sydney (M) LLGA	125	244	26	416	234
Parramatta (C) LLGA	946	1,416	117	584	231
Penrith (C) LLGA	587	1,114	95	112	251
Randwick (M) LLGA	3,085	1,492	44	1,031	578
Rockdale (M) LLGA	3,512	1,691	24	623	185
Ryde (M) LLGA	545	2,615	60	1,069	230
Strathfield (M) LLGA	324	779	57	272	103
Sutherland (S) LLGA	720	1,316	88	381	164
Sydney (C) LLGA	1,610	741	88	642	433
Warringah (S) LLGA	261	2,708	84	468	221
Waverley (M) LLGA	550	736	52	222	1,289
Willoughby (M) LLGA	303	853	36	754	376
Wollondilly (S) LLGA	34	98	20	17	31
Woollahra (M) LLGA	337	486	36	255	1,019
Wyong (S) LLGA	57	214	17	32	51
TOTAL SYDNEY (SD)	40,942	59,581	2,616	14,712	10,028

Local Government Area	INDIA	INDONESIA	IRELAND (REPUBLIC)	LEBANON	MALAYSIA
Ashfield (M) LLGA	251	123	236	730	169
Auburn (M) LLGA	337	51	164	2,623	99
Bankstown (C) LLGA	404	148	466	5,404	194
Baulkham Hills (S) LLGA	448	149	308	247	669
Blacktown (C) LLGA	985	253	749	886	416
Blue Mountains (C) LLGA	138	60	229	24	109
Botany (M) LLGA	154	244	120	398	144
Burwood (M) LLGA	172	102	153	938	115
Camden (M) LLGA	18	9	64	32	18
Campbelltown (C) LLGA	403	104	534	532	202
Canterbury (M) LLGA	502	358	379	8,975	366
Concord (M) LLGA	91	35	85	335	108
Drummoyne (M) LLGA	95	48	105	89	57
Fairfield (C) LLGA	346	230	391	1,447	301
Gosford (C) LLGA	138	53	261	21	80
Hawkesbury (S) LLGA	59	31	91	70	221
Holroyd (M) LLGA	453	44	296	1,836	119
Hornsby (S) LLGA	483	197	339	630	522
Hunter's Hill (M) LLGA	28	12	75	20	33
Hurstville (M) LLGA	176	102	181	597	161
Kogarah (M) LLGA	168	87	142	607	196
Ku-ring-gai (M) LLGA	424	256	265	132	557
Lane Cove (M) LLGA	166	88	84	116	122
Leichhardt (M) LLGA	217	167	273	149	157
Liverpool (C) LLGA	283	75	292	655	164
Manly (M) LLGA	96	83	214	21	84
Marrickville (M) LLGA	206	582	231	2,626	253
Mosman (M) LLGA	103	42	107	12	85
North Sydney (M) LLGA	309	137	292	79	202
Parramatta (C) LLGA	664	193	441	4,224	379
Penrith (C) LLGA	658	92	656	208	310
Randwick (M) LLGA	524	1,263	655	600	2,216
Rockdale (M) LLGA	300	163	278	2,207	255
Ryde (M) LLGA	526	339	275	855	617
Strathfield (M) LLGA	258	41	86	533	156
Sutherland (S) LLGA	363	218	400	340	387
Sydney (C) LLGA	299	449	474	709	443
Warringah (S) LLGA	413	326	532	143	372
Waverley (M) LLGA	344	210	347	156	200
Willoughby (M) LLGA	227	127	157	611	292
Wollondilly (S) LLGA	13	12	51	30	21
Woollahra (M) LLGA	180	122	236	99	184
Wyong (S) LLGA	47	39	233	9	50
TOTAL SYDNEY (SD)	12,469	7,464	11,947	40,955	11,805

Local Government Area	MALTA	THE NETH-ERLANDS	NEW ZEALAND	NORTHERN IRELAND	PAPUA NEW GUINEA
Ashfield (M) LLGA	114	80	809	49	59
Auburn (M) LLGA	236	52	475	76	25
Bankstown (C) LLGA	810	398	1,132	195	76
Baulkham Hills (S) LLGA	469	666	1,326	191	168
Blacktown (C) LLGA	4,219	1,301	1,770	444	111
Blue Mountains (C) LLGA	60	612	741	98	76
Botany (M) LLGA	452	51	552	49	13
Burwood (M) LLGA	84	51	449	29	74
Camden (M) LLGA	127	96	172	31	14
Campbelltown (C) LLGA	378	535	1,167	419	101
Canterbury (M) LLGA	506	205	1,693	133	119
Concord (M) LLGA	133	60	295	22	26
Drummoyne (M) LLGA	114	71	628	21	31
Fairfield (C) LLGA	2,350	485	1,139	211	51
Gosford (C) LLGA	161	554	1,466	158	117
Hawkesbury (S) LLGA	294	366	410	81	43
Holroyd (M) LLGA	3,112	283	809	148	37
Hornsby (S) LLGA	128	721	2,093	185	219
Hunter's Hill (M) LLGA	18	35	248	10	59
Hurstville (M) LLGA	191	132	775	76	83
Kogarah (M) LLGA	148	108	685	75	40
Ku-ring-gai (M) LLGA	43	492	2,116	102	309
Lane Cove (M) LLGA	16	119	885	46	82
Leichhardt (M) LLGA	428	197	1,734	73	73
Liverpool (C) LLGA	828	413	737	164	69
Manly (M) LLGA	16	194	1,369	74	48
Marrickville (M) LLGA	361	139	1,514	61	57
Mosman (M) LLGA	12	138	894	25	62
North Sydney (M) LLGA	38	236	2,522	95	103
Parramatta (C) LLGA	829	520	1,988	222	120
Penrith (C) LLGA	1,395	1,265	1,138	508	87
Randwick (M) LLGA	571	336	3,020	244	176
Rockdale (M) LLGA	580	162	1,542	118	94
Ryde (M) LLGA	209	305	1,738	123	157
Strathfield (M) LLGA	61	65	353	36	29
Sutherland (S) LLGA	312	1,009	2,140	268	179
Sydney (C) LLGA	476	313	4,295	121	155
Warringah (S) LLGA	119	1,698	3,761	327	229
Waverley (M) LLGA	150	253	2,622	81	73
Willoughby (M) LLGA	36	224	1,472	63	302
Wollondilly (S) LLGA	91	199	167	49	28
Woollahra (M) LLGA	98	206	1,866	61	79
Wyong (S) LLGA	205	379	1,006	129	45
TOTAL SYDNEY (SD)	20,978	15,724	57,713	5,691	4,098

Local Government Area	THE PHILIPP-INES	POLAND	PORTUGAL	SCOTLAND	SINGAPORE
Ashfield (M) LLGA	495	687	209	365	64
Auburn (M) LLGA	485	406	58	354	28
Bankstown (C) LLGA	338	1,608	76	1,110	100
Baulkham Hills (S) LLGA	239	148	19	808	186
Blacktown (C) LLGA	1,907	1,364	95	2,052	186
Blue Mountains (C) LLGA	76	157	5	734	40
Botany (M) LLGA	411	328	178	315	56
Burwood (M) LLGA	185	227	60	225	53
Camden (M) LLGA	16	18	4	203	14
Campbelltown (C) LLGA	402	517	41	1,671	73
Canterbury (M) LLGA	888	635	568	783	132
Concord (M) LLGA	53	123	29	198	24
Drummoyne (M) LLGA	48	58	50	333	42
Fairfield (C) LLGA	1,261	1,546	222	1,008	104
Gosford (C) LLGA	124	96	6	1,029	30
Hawkesbury (S) LLGA	40	33	4	293	25
Holroyd (M) LLGA	169	391	29	631	46
Hornsby (S) LLGA	326	245	20	1,013	177
Hunter's Hill (M) LLGA	17	64	7	129	19
Hurstville (M) LLGA	246	114	37	483	73
Kogarah (M) LLGA	155	96	40	423	43
Ku-ring-gai (M) LLGA	179	179	10	783	266
Lane Cove (M) LLGA	135	160	2	257	63
Leichhardt (M) LLGA	317	157	282	533	65
Liverpool (C) LLGA	222	831	98	1,004	52
Manly (M) LLGA	50	61	13	483	61
Marrickville (M) LLGA	846	368	3,036	436	101
Mosman (M) LLGA	73	71	4	244	43
North Sydney (M) LLGA	263	223	11	559	153
Parramatta (C) LLGA	710	727	63	1,282	125
Penrith (C) LLGA	747	556	52	1,732	99
Randwick (M) LLGA	446	682	363	1,238	352
Rockdale (M) LLGA	462	195	250	735	87
Ryde (M) LLGA	548	431	32	914	221
Strathfield (M) LLGA	97	177	22	153	45
Sutherland (S) LLGA	280	215	49	1,411	161
Sydney (C) LLGA	346	544	755	843	237
Warringah (S) LLGA	305	260	53	1,666	190
Waverley (M) LLGA	239	1,045	251	664	205
Willoughby (M) LLGA	185	208	31	447	97
Wollondilly (S) LLGA	27	19	0	224	7
Woollahra (M) LLGA	120	692	92	378	152
Wyong (S) LLGA	67	87	16	815	13
TOTAL SYDNEY (SD)	14,545	16,749	7,242	30,961	4,310

Local Government Area	SOUTH AFRICA	SPAIN	SRI LANKA	TURKEY	U.S.A.
Ashfield (M) LLGA	99	208	114	302	89
Auburn (M) LLGA	55	164	109	2,260	41
Bankstown (C) LLGA	229	136	218	304	203
Baulkham Hills (S) LLGA	333	55	217	40	376
Blacktown (C) LLGA	507	302	304	750	227
Blue Mountains (C) LLGA	134	16	29	9	223
Botany (M) LLGA	66	185	20	558	44
Burwood (M) LLGA	39	88	178	142	53
Camden (M) LLGA	26	4	10	4	36
Campbelltown (C) LLGA	718	162	101	91	191
Canterbury (M) LLGA	327	359	245	323	139
Concord (M) LLGA	59	74	118	69	39
Drummoyne (M) LLGA	60	61	38	78	100
Fairfield (C) LLGA	190	529	208	817	163
Gosford (C) LLGA	225	26	48	9	265
Hawkesbury (S) LLGA	67	14	24	2	141
Holroyd (M) LLGA	123	98	100	219	82
Hornsby (S) LLGA	563	58	258	38	453
Hunter's Hill (M) LLGA	50	11	4	8	75
Hurstville (M) LLGA	149	47	65	23	120
Kogarah (M) LLGA	166	54	27	44	108
Ku-ring-gai (M) LLGA	1,651	33	120	38	831
Lane Cove (M) LLGA	198	19	44	54	234
Leichhardt (M) LLGA	142	217	83	106	323
Liverpool (C) LLGA	149	197	103	149	111
Manly (M) LLGA	227	18	17	32	323
Marrickville (M) LLGA	112	463	43	769	241
Mosman (M) LLGA	174	13	20	23	268
North Sydney (M) LLGA	398	49	94	53	621
Parramatta (C) LLGA	351	129	300	525	255
Penrith (C) LLGA	491	141	147	138	220
Randwick (M) LLGA	412	300	150	234	411
Rockdale (M) LLGA	201	157	33	195	130
Ryde (M) LLGA	396	101	415	178	269
Strathfield (M) LLGA	69	52	337	164	67
Sutherland (S) LLGA	569	68	60	64	489
Sydney (C) LLGA	247	292	113	401	1,161
Warringah (S) LLGA	697	76	87	94	885
Waverley (M) LLGA	623	213	39	100	382
Willoughby (M) LLGA	310	47	75	196	293
Wollondilly (S) LLGA	29	13	8	0	48
Woollahra (M) LLGA	636	116	56	37	542
Wyong (S) LLGA	77	11	24	5	99
TOTAL SYDNEY (SD)	12,344	5,376	4,803	9,645	11,371

Local Government Area	U.S.S.R. (n.e.i.)	VIETNAM	WALES	YUGOSLAVIA	OTHER
Ashfield (M) LLGA	154	555	46	584	2,754
Auburn (M) LLGA	505	2,522	34	1,364	2,147
Bankstown (C) LLGA	955	3,216	166	3,004	3,250
Baulkham Hills (S) LLGA	150	85	155	464	1,429
Blacktown (C) LLGA	505	479	242	3,027	4,224
Blue Mountains (C) LLGA	109	16	140	163	602
Botany (M) LLGA	111	275	34	939	2,787
Burwood (M) LLGA	250	661	24	606	1,144
Camden (M) LLGA	16	2	33	169	110
Campbelltown (C) LLGA	199	267	328	993	3,143
Canterbury (M) LLGA	281	4,814	116	1,484	6,641
Concord (M) LLGA	133	103	19	283	582
Drummoyne (M) LLGA	31	13	32	165	582
Fairfield (C) LLGA	1,060	9,640	113	7,342	18,441
Gosford (C) LLGA	75	21	209	159	695
Hawkesbury (S) LLGA	34	2	75	246	356
Holroyd (M) LLGA	273	120	96	1,267	1,686
Hornsby (S) LLGA	316	150	197	241	2,207
Hunter's Hill (M) LLGA	54	12	18	55	205
Hurstville (M) LLGA	98	88	82	1,295	1,043
Kogarah (M) LLGA	133	32	58	898	813
Ku-ring-gai (M) LLGA	202	51	138	170	3,117
Lane Cove (M) LLGA	76	27	50	194	1,173
Leichhardt (M) LLGA	109	169	81	549	1,715
Liverpool (C) LLGA	209	815	141	1,972	3,030
Manly (M) LLGA	59	31	101	142	849
Marrickville (M) LLGA	169	4,386	68	2,601	4,230
Mosman (M) LLGA	46	10	49	60	657
North Sydney (M) LLGA	116	87	108	209	2,184
Parramatta (C) LLGA	445	732	185	1,128	3,626
Penrith (C) LLGA	252	82	305	1,589	1,794
Randwick (M) LLGA	554	370	173	797	4,268
Rockdale (M) LLGA	190	264	110	4,443	1,973
Ryde (M) LLGA	206	170	139	807	3,314
Strathfield (M) LLGA	287	751	19	363	1,005
Sutherland (S) LLGA	179	205	312	641	1,791
Sydney (C) LLGA	557	986	154	1,065	3,904
Warringah (S) LLGA	180	162	375	1,342	3,821
Waverley (M) LLGA	1,361	57	117	414	2,899
Willoughby (M) LLGA	163	58	91	756	2,532
Wollondilly (S) LLGA	185	0	42	129	218
Woollahra (M) LLGA	229	31	71	207	1,911
Wyong (S) LLGA	58	5	140	172	312
TOTAL SYDNEY (SD)	11,274	32,522	5,186	44,498	105,164

Local Government Area	NOT STATED	TOTAL
Ashfield (M) LLGA	884	40,395
Auburn (M) LLGA	913	47,141
Bankstown (C) LLGA	1,928	151,562
Baulkham Hills (S) LLGA	869	102,803
Blacktown (C) LLGA	2,418	192,438
Blue Mountains (C) LLGA	831	63,871
Botany (M) LLGA	738	34,273
Burwood (M) LLGA	618	28,560
Camden (M) LLGA	145	18,868
Campbelltown (C) LLGA	1,159	121,295
Canterbury (M) LLGA	2,317	128,498
Concord (M) LLGA	280	23,403
Drummoyne (M) LLGA	561	30,595
Fairfield (C) LLGA	2,391	153,529
Gosford (C) LLGA	1,131	109,272
Hawkesbury (S) LLGA	451	43,635
Holroyd (M) LLGA	977	78,243
Hornsby (S) LLGA	1,009	117,565
Hunter's Hill (M) LLGA	166	12,281
Hurstville (M) LLGA	682	63,214
Kogarah (M) LLGA	515	45,951
Ku-ring-gai (M) LLGA	951	100,183
Lane Cove (M) LLGA	488	29,112
Leichhardt (M) LLGA	1,822	56,303
Liverpool (C) LLGA	1,573	93,215
Manly (M) LLGA	877	35,727
Marrickville (M) LLGA	2,745	81,648
Mosman (M) LLGA	557	25,775
North Sydney (M) LLGA	1,645	49,923
Parramatta (C) LLGA	2,246	130,786
Penrith (C) LLGA	1,518	135,339
Randwick (M) LLGA	3,521	115,620
Rockdale (M) LLGA	1,634	83,351
Ryde (M) LLGA	1,085	89,253
Strathfield (M) LLGA	412	25,671
Sutherland (S) LLGA	1,839	175,193
Sydney (C) LLGA	7,601	86,315
Warringah (S) LLGA	2,349	173,948
Waverley (M) LLGA	2,308	59,847
Willoughby (M) LLGA	992	51,892
Wollondilly (S) LLGA	230	24,920
Woollahra (M) LLGA	2,739	51,057
Wyong (S) LLGA	968	82,359
TOTAL SYDNEY (SD)	61,083	3,364,829

APPENDIX 2

SCREENING QUESTION

CONTACT SHEET
HOUSEHOLD HEALTH SURVEY

1	9 9 9				
REC. (1)	G.P. I.D. (2-4)	ST.PT. (5-6)	H/HLD (7-8)	INTV ID (9-10)

Good morning/afternoon/evening. My name is _____ from the Public Policy Research Centre. We are doing a survey for the University of Sydney on the health of the community, and would like to ask you some questions.

1. Could you please tell me if anyone in the household has seen a doctor about their own health, either at a surgery or at home, in the past two weeks?
   Yes...1
   No....2 -->Q5
   Dk....9 -->Q5

2. Who was it who saw the doctor? Could you tell me their age and sex?

3. [ASK FOR EACH PERSON WHO SAW A DOCTOR - IF OTHER/DK --->Q5]
   Was the doctor a General Practitioner or another type of doctor?

4. Could you also tell me the age and sex of any other people in the household?

   [REQUEST INTERVIEWS WITH THOSE ELIGIBLE AND PROCEED TO INTERVIEW SCHEDULE]

5. In that case, I don't need to do a full interview, but could you tell me the age and sex of each member of the household for our statistics?

6. Also, a researcher at Sydney University is doing a survey on a common problem in the community. Could you tell me if, in the past year, there has been a period of 2 weeks or more in which you felt sad and down, or when you lost all interest and pleasure in things that you usually care about and enjoy?
   Yes....1
   No.....2 (11)
   Dk/Ns..9

   [IF YES] I'll leave this letter with you. It tells you a little about the researcher, and how you might contact her.

Thank you for your co-operation

		Q1	Q2 or Q4		Q3		
PERSON	R/SHIP	CONS Y N DK	AGE <1=00 >99=99	SEX M F	TYPE GP O B NA DK	INT/COMP Y N NA	Off. Use Only
01		1 2 9		1 2	1 2 3 9	1 2 9	(12-19)
02		1 2 9		1 2	1 2 3 9	1 2 9	(20-27)
03		1 2 9		1 2	1 2 3 9	1 2 9	(28-35)
04		1 2 9		1 2	1 2 3 9	1 2 9	(36-43)
05		1 2 9		1 2	1 2 3 9	1 2 9	(44-51)
06		1 2 9		1 2	1 2 3 9	1 2 9	(52-59)
07		1 2 9		1 2	1 2 3 9	1 2 9	(60-67)
08		1 2 9		1 2	1 2 3 9	1 2 9	(68-75)
09		1 2 9		1 2	1 2 3 9	1 2 9	(11-18)
10		1 2 9		1 2	1 2 3 9	1 2 9	(19-26)

APPENDIX 3

ORIGINAL LETTER AND FOLLOW-UP LETTER

ECT CONTACT:

Telex No: UNISYD 26169
DX 1154

The University of Sydney
N.S.W. 2006
DEPARTMENT OF SOCIAL WORK

Stuart J. Rees
fessor of Social Work
692 4091

General Office:
692 2222
ext. 2650

12th August 1987

Zita Mullaly, a researcher from the Department of Social Work at Sydney University, is interested in speaking with people who have felt sad and down recently. Zita is interested in hearing your views as she is doing research on this important topic. Your contribution would be appreciated, and your comments would be respected by being kept entirely confidential.

I would be grateful if you would ring her on 692-2650 if you would like more information, or fill in the attached form.

If Zita does not hear from you she may send you a reminder.

[Redaction]

[Redaction]

Professor Stuart Rees

Zita Mullaly

I would be willing to talk to Zita Mullaly

Name:

I would prefer to be contacted during the day/evening

Telephone No:

Please detach and return in the prepaid envelope provided.

DIRECT CONTACT:

Telex No: UNISYD 26169
DX 1154

The University of Sydney
N.S.W. 2006
DEPARTMENT OF SOCIAL WORK

Stuart J. Rees
Professor of Social Work
692 4091

General Office:
692 2222
ext. 2650

22nd February, 1988

Last September you took part in a general household survey conducted by the Department of Community Medicine at the University of Sydney. You might remember being asked if you had felt sad and down in the past 12 months. If you had felt this way, you were handed a short letter which invited you, if you were willing to talk about your experience, to ring Zita Mullaly.

Zita is still interested in hearing your views on the important topic of people's feelings about being sad and down and comments about losing interest in things you had previously enjoyed.

In case you may have overlooked the original letter or not appreciated that your observations would assist in this research project, this letter comes as a reminder. Your contribution would be appreciated and your comments would be respected by being kept entirely confidential.

If you would like more details or would be willing to be interviewed for this research project, please ring Zita on 692 2650 or fill in the attached form.

[Redaction]

Professor Stuart Rees

[Redaction]

Zita Mullaly

I would be willing to talk to Zita Mullaly

Name:

I would prefer to be contacted during the day/evening

Telephone No:

Please detach and return in the prepaid envelope provided.

APPENDIX 4

INTERVIEW SCHEDULE (AMENDED BROWN AND HARRIS) ZUNG SELF-RATING DEPRESSION SCALE CORNEY AND CLARE SOCIAL PROBLEMS SELF-REPORT QUESTIONNAIRE

INTERVIEW SCHEDULE

Health

Has anyone in your family been ill in the last twelve months?

Has anyone been admitted to or left hospital in the last twelve months?

Any surgical operations in the last twelve months?

Are there any chronic health problems?

e.g. high blood pressure
asthma
chest problems
kidney trouble
migraine
trouble with periods

Have any relatives or close friends died?

Have any relatives been a worry to you for other reasons?
e.g. because of old age, drinking or gambling problem etc.

Respondent's own past health:

In your life have you had any operations?

When?

What?

Have you ever had any serious illness?

When?

What?

Did you have any other childhood problems?
e.g. problems at school or in your family?

In the last twelve months*

Has there been any nervous trouble in the family?

Have there been any accidents?

Has there been any pregnancy in the family? Any miscarriages?

Any babies born?

Anyone lost a baby?

For how long have you had experiences at depression? (ask if not covered earlier).

(a) within the past month
(b) Between 1-3 months
(c) Between 3-6 months
(d) Between 9-12 months
(e) From 1-2 years
(f) From 2-3 years
(g) Longer between 3 years

Role Changes

Has anyone in the family married in the last twelve months?

Anyone engaged?

Anyone separated or divorced?

Has anyone retired?

Anyone started school, college, university?

Anyone taken any important examinations?

Have you made any new friends?

Or lost anyone you were close to? Why was this?

Have there been any big changes in the amount you see of your friends or relatives?

As if appropriate:

Do you have a boyfriend/girlfriend?

Have you thought of getting engaged or married?

Leisure and Interaction

Has there been just the _____ of you at home during this twelve months?

Has anyone come to stay? For how long?

Has anyone left the household?

Is there anyone you see much less of? Why is this?

What do you do with your leisure time?
e.g. watch telly

Do you feel you have enough leisure time?

Are there things you'd like to do but can't?
e.g. shortage of money, transport

Do you have friends over?

Have you had any difficulties with friends? Or been worried about them?

Have you had a holiday in the past twelve months? How was it?

Support Networks and Coping

What do you think a friend is?

How many people could you count as friends?

How many people could you call on in times of trouble?

Who are they? e.g. spouse
sister

How helpful have you found friends and relatives to be when you've had difficulties?

Very helpful
Fairly helpful
A little helpful
Totally unhelpful

What would you say you found really helpful?

e.g. practical help
talking things through

When in your life have you felt the lowest?

Could you tell me what was happening at that time?

When you feel "low" what exactly do you do?

e.g. eat
listen to records

Employment

Do you enjoy your job?

Has anything happened at work?

Have you been off work at all or put onto a new job, or changed jobs?

Has anyone you worked with closely left in the last twelve months?

How do you get on with your workmates?

Have you any trouble i.e. difficulties with them?

Were there any other difficulties at work? (e.g. long hours, travel etc.)

What do you like about your job?

Is there anything you don't like about it?

Is there any other work you would have liked better?

Have you felt that the demands made on you at work were too great?

Are you a member of a trade union?

Are there times in your work when you don't know what is expected of you?

Have you been expecting any changes in your job?

How do you feel about the future, do you think you'll stay in this job?

Have you done different types of work in the past?

Housing

How long have you lived in your present house?

Do you own/rent it?

Do you like living here?

Have you had any problems with not enough room?
sharing facilities?

Do you feel it's private enough?

What is the neighbourhood like?

How do you get on with your neighbours?

Have you ever felt cut off in your present home -
e.g. too far from friends at work?

Have you ever considered living anywhere else?

Money

Have you any money worries? Especially in the last twelve months?

Have you gone without things you really need?

Does anyone contribute to house hold expenses?
e.g. children who work

Have you been getting any social security benefits?

Crisis

Has there been any crisis/emergency?

Has anything happened in the home? e.g. burglary.

Have you had to break bad news to anyone?

Have there been any legal troubles?

Have you had to go to court?

Have you or anyone in the family had any contact with the police at all?

Have you or anyone had contact with a social agency?

Have any of your relatives had any crisis or troubles with which you've had to help?
e.g. anyone had to stay with a sick relative?

Has there been any trouble or difficulty concerning friends in the past year?

Forecasts

Have you or any member of the family had any unexpected news in the past twelve months about anything that has happened or is going to happen?

e.g. rehousing, redundancy.

Have you had any news that has shaken you at all?

e.g. discovering child stealing at school

Relationships (permanent/living-in)

In the past twelve months have you and your husband/ boyfriend/wife/girlfriend been living together/

If negative response:

Have you been separated for any time in the last year?

Have either of you ever considered separation or divorce?

Would you say there are any problems in your relationship?

How often would you have quarrels or tiffs?

What are they usually about?

e.g. money, managing the children

Do you feel you can talk to him/her easily?

Do you talk to him/her about things that worry you?

Do you wish you could confide in him/her?

When he/she has problems or worries does he/she talk them out with you?

What about the sexual side of things?

Have there been any difficulties or problems?

Do you like doing the same things when you're together?

Interaction with Parents (if appropriate)

How do you get on with your parents?

Probe for mother and father

Would you say your mother/father is an affectionate person?

Does you mother/father show interest in you/in the things you do?

Do you feel you could confide in your parents?

General

Do you attend church regularly?

How often?

Do you enjoy a drink?

Do you think you have a problem with drink?

When do you find yourself needing a drink most?

When in your life have you felt the lowest?

Could you tell me what was happening for you (in your life) at that time?

When do you feel you can't cope?

Is this feeling connected to anyting in particular?

Has anything particularly disappointing happened over the past twelve months that you haven't mentioned already?

Have you had to make any important decisions over this time?

Has anything given you special pleasure?

Anything turned out better than expected?

If you like so far:-

Are there things you wish had turned out differently?

Any regret you have?

What if anything gives you special fulfilment or satisfaction in our life?

	A Little of the Time	Some of the Time	Good Part of the Time	Most of the Time
1. I feel down-hearted and blue				
2 Morning is when I feel the best				
3. I have crying spells or feel like it				
4. I have trouble sleeping at night				
5. I eat as much as I used to				
6. I still enjoy sex				
7. I notice that I am losing weight				
8. I have trouble with constipation				
9. My heart beats faster than usual				
10. I get tired for no reason				
11. My mind is clear as it used to be				
12. I find it easy to do the things I used to				
13. I am restless and can't keep still				
14. I feel hopeful about the future				
15. I am more irritable than usual				
16. I find it easy to make decisions				
17. I feel that I am useful and needed				
18. My life is pretty full				
19. I feel that others would be better off if I were dead				
20. I still enjoy the things I used to do				

APPENDIX

Social Questionnaire

Please underline the most appropriate answer

A. Housing (*Everyone answer*)

1	Are your housing conditions adequate for you and your family's needs?	Adequate	Slightly inadequate	Markedly inadequate	Severely inadequate
2	How satisfied are you with your present accommodation?	Satisfied	Slightly dissatisfied	Markedly dissatisfied	Severely dissatisfied

B. Work

FOR ALL MEN AND WOMEN WORKING OUTSIDE THE HOME

Tick box if not applicable ☐

3	How satisfied are you with your present job?	Satisfied	Slightly dissatisfied	Markedly dissatisfied	Severely dissatisfied
4	Do you have problems getting on with any of the people at your work?	No problems	Slight problems	Marked problems	Severe problems

FOR HOUSEWIVES WITH NO OUTSIDE WORK

Tick box if not applicable ☐

5	How satisfied are you with being a housewife?	Satisfied	Slightly dissatisfied	Markedly dissatisfied	Severely dissatisfied

FOR HOUSEWIVES WITH A FULL OR PART-TIME JOB OUTSIDE THE HOME

Tick box if not applicable ☐

6	How satisfied are you with working and running a home?	Satisfied	Slightly dissatisfied	Markedly dissatisfied	Severely dissatisfied

FOR THOSE WHO ARE NOT WORKING (RETIRED, UNEMPLOYED, OR OFF SICK)

Tick box if not applicable ☐

7	How satisfied are you with this situation?	Satisfied	Slightly dissatisfied	Markedly dissatisfied	Severely dissatisfied

C. Financial circumstances (*Everyone answer*)

8	Is the money coming in adequate for you and your family's needs?	Adequate	Slightly inadequate	Markedly inadequate	Severely inadequate
9	Do you have any difficulties in meeting bills and other financial commitments?	No difficulties	Slight difficulties	Marked difficulties	Severe difficulties

FOR ALL THOSE WHO ARE NOT MARRIED/DO NOT HAVE A STEADY RELATIONSHIP

Tick box if not applicable ☐

23	How satisfied are you with this situation?	Satisfied	Slightly dissatisfied	Markedly dissatisfied	Severely dissatisfied

F. Domestic life

FOR THOSE WITH CHILDREN UNDER 18

Tick box if not applicable ☐

24	Do you have any difficulties coping with your children?	No difficulties	Slight difficulties	Marked difficulties	Severe difficulties
25	How satisfied do you feel with your relationship with the children?	Satisfied	Slightly dissatisfied	Markedly dissatisfied	Severely dissatisfied

FOR THOSE WITH CHILDREN OF SCHOOL AGE

Tick box if not applicable ☐

26	Are there any problems involving your children at school?	No problems	Slight problems	Marked problems	Severe problems

FOR ALL THOSE WITH OTHER ADULTS LIVING WITH THEM (INCLUDING RELATIVES BUT EXCLUDING SPOUSE)

Tick box if not applicable ☐

27	Do you have any problems about sharing household tasks?	No problems	Slight problems	Marked problems	Severe problems
28	Do you have any difficulties with the other adults in your household?	No difficulties	Slight difficulties	Marked difficulties	Severe difficulties
29	How satisfied are you with this arrangement?	Satisfied	Slightly dissatisfied	Markedly dissatisfied	Severely dissatisfied

G. Legal matters (*Everyone answer*)

30	Do you have any legal problems (custody, maintenance, compensation etc.)?	No problems	Slight problems	Marked problems	Severe problems

H. For those who are living alone

Tick box if not applicable ☐

31	Do you have any difficulties living and managing on your own?	No difficulties	Slight difficulties	Marked difficulties	Severe difficulties
32	How satisfied are you with living on your own?	Satisfied	Slightly dissatisfied	Markedly dissatisfied	Severely dissatisfied

I. Other (*Everyone answer*)

33	Do you have any other social problems or problems?	No problems	Slight problems	Marked problems	Severe problems

If so, please specify...

10	How satisfied are you with your financial position?	Satisfied	Slightly dissatisfied	Markedly dissatisfied	Severely dissatisfied

D. Social contacts (*Everyone answer*)

11	How satisfied are you with the amount of time you are able to go out?	Satisfied	Slightly dissatisfied	Markedly dissatisfied	Severely dissatisfied
12	Do you have any problems with your neighbours?	No problems	Slight problems	Marked problems	Severe problems
13	Do you have any problems getting on with any of your friends?	No problems	Slight problems	Marked problems	Severe problems
14	How satisfied are you with the amount of time you see your friends?	Satisfied	Slightly dissatisfied	Markedly dissatisfied	Severely dissatisfied
15	Do you have any problems getting on with any close relative? (include parents, in-laws or grown-up children)	No problems	Slight problems	Marked problems	Severe problems
16	How satisfied are you with the amount of time you see your relatives?	Satisfied	Slightly dissatisfied	Markedly dissatisfied	Severely dissatisfied

E. Marriage and boyfriends/girlfriends

17	What is your marital status?	Single	Married/ cohabiting	Widowed	Separated	Divorced

FOR ALL THOSE WHO ARE MARRIED OR HAVE A STEADY RELATIONSHIP

Tick box if not applicable ☐

18	Do you have difficulty confiding in your partner?	No difficulty	Slight difficulty	Marked difficulty	Severe difficulty
19	Are there any sexual problems in your relationship?	No problems	Slight problems	Marked problems	Severe problems
20	Do you have any other problems getting on together?	No problems	Slight problems	Marked problems	Severe problems
21	How satisfied in general are you with your relationship?	Satisfied	Slightly dissatisfied	Markedly dissatisfied	Severely dissatisfied
22	Have you recently been so dissatisfied that you have considered separating from your partner?	No	Sometimes	Often	Yes, planned or recent separation

APPENDIX 5

INTERVIEW SCHEDULE FOR GENERAL PRACTITIONERS

INTERVIEW SCHEDULE

General Practitioners' Perspectives on Treatment of Depression

1. Location of Practice.

2. Type of Practice - group, solo, partnership.

3. Patients' method of payment - bulk-billing, fee-for-service, combination of both.

4. Type of patients? Ethnic background of area.

5. Experience/familiarity with the area:
   Ask how long he/she worked in the area?
   Does he/she live in the area?
   How well do they know the area?

6. What is depression? How do you recognise depression?

7. Who, in your view, gets depressed? Ask for clinical experience and evidence.

8. What causes depression? Any particular triggers or associations?

9. What is the medical treatment for depression? Is this what you do?
   (a) Do you have time within a consultation to recognise depression? (e.g. masked depression).
   (b) Do you have the time within a consultation to treat depression?
   (c) Is there any particular treatment which you prefer?
   (d) Is depression a medical problem which interests you?
   (e) Did your medical training equip you to recognise and treat depression?

9. Could you describe a typical depressed patient in your practice?

10. Do you refer patients elsewhere for treatment?
    If 'yes', why do you make such referrals?
    Do patients accept such referrals?

11. Do you refer patients to people other than doctors or psychiatrists?

12. Have you ever worked in association with other non-medical professionals such as social workers, community nurses?

13. Are these resoruces in your area?

14. Would you see any value in referring patients to a social worker?