ABSTRACT

VOICE OF THE DRUG:
INTERPRETING MEDICALIZED DISEMPOWERMENT
IN WOMEN’S NARRATIVES OF DEPRESSION

by Siri Rebecca Hoogen

This paper presents a qualitative investigation of the phenomenon of medicalization in women’s narratives of depression. Feminist research ethics informed the research and creative process, including the recruitment and interviewing of the women participants, the analysis of their narratives, and the construction of the creative-nonfiction representations of their stories. Four personal narratives were analyzed for the role medicalization played in women’s understanding of their depression and for the possibilities of disempowerment in a medicalized understanding. Each narrative is presented as a story and shows the tension between the medicalized understanding of depression, which is argued to be our cultural master narrative; a personal sense-making of depression, which is how women fit the experience into the context of their lives; and a feminist analysis of structures of disempowerment in women’s lives. A discussion of the ramifications of these analyses follows, with a suggestion for future direction in this area and methodology.
VOICE OF THE DRUG:

INTERPRETING MEDICALIZED DISEMPOWERMENT

IN WOMEN’S NARRATIVES OF DEPRESSION

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Prologue

Last fall, after innumerable emails and messages volleyed between answering machines, I at last met Nina for a conversation about her experiences taking antidepressant drugs. We had become acquainted only a week before, when she with her husband and daughter attended a dinner party my husband and I had put together. My first sight was of her standing unacknowledged and unwelcomed at the front door as her husband swept past her to greet his friends in the kitchen. She stood there alone for a moment, a pretty woman in her forties: hair softly styled around her face, clothes neat and stylish. She kept a friendly if tremulous smile on her face as she looked about the room, searching for hosts she hadn’t yet met.

I hurried to welcome her and introduce myself.

“Siri,” she smiled at me, when I had. “How lovely of you to invite us here. It’s wonderful to finally start meeting people here in town.” She was warm as her expression promised, and while our spouses puttered and guffawed in the kitchen, Nina and I enjoyed a few moments of the usual getting-to-know-you social chitchat. Nina and her daughter, I learned, had recently moved to town; Nina’s husband, an upper-level manager of a large corporation, had just taken a new position here. Nina had been a corporate lawyer in New York, their last home, but she was not yet licensed to practice in Ohio and was currently at loose ends. “I’m taking lots of Pilates classes,” she laughed. When I revealed I was pursuing graduate studies in psychology in the school here, Nina asked what topic I researched.

“Well,” I tried to paraphrase, “I’m interviewing depressed women about taking antidepressants, and how that relates to what they thought was depressing them in the first place.” It was as bland a reduction I could muster, one which I had prepared after my usual response—in which I rail against the financial interests of pharmaceutical companies in the medicalization of discontent—had offended one too many listeners who had, or who had known someone who had, turned their lives around thanks to the intervention of a chemical savior.

“How interesting,” Nina replied, and then offered, “I would have a lot to say about that. I’ve been on antidepressants for most of my life.”

A week of negotiation followed.

First Nina was busy, then she was concerned that her identity and participation in my study might discredit her husband.

“Let’s just meet and have coffee,” I suggested to the unwinding spool of her answering machine. “Totally informal. If you have any questions about my study I can try to explain it better…I’d even just like to run some ideas by you for questions I might ask other women.” She had, at that dinner, mentioned that she would like to talk about experiences she had in common with depressed friends, and I hoped her feedback could help guide my inquiry.

Nina called me back and indicated such circumspection was unnecessary. “I’d love to talk with you—I’ve just been so busy.”

Doing Pilates? I thought.

But Nina assured me she would enjoy meeting with me to talk about my study, and we set a date to speak in person at the school’s psychology clinic.

When we met again, Nina greeted me with an airy buss on the cheek and followed me into an empty therapy room. “I’ve thought about it, and I decided I’d like to share with you what depression is like for me.” I waited, and she continued. “Have you ever read that book? There’s this book—I don’t remember what it was titled, or who wrote it; though it was a Japanese author—that’s about these people who live in a pit on the beach. They can’t escape the pit; when
they try to climb out, the sand of the pit’s walls just crumbles around them. So they can either come to terms with living in the pit, or try to escape and be buried by the collapsing sand.”

“Sounds like an interesting story,” I commented, as we sat down.

“Well, that’s what depression is like for me. I tried to escape for a while—but the medicine doesn’t help you escape the pit. It just makes it easier to live there.”

_Easier_, I wondered. At the dinner the other week, Nina had mentioned how antidepressants make her feel numb, blunted, and I wanted to pursue this description further.

“How do you feel, now that you’re taking antidepressants?” I asked.

“What it makes me feel,” she said, twisting her hands, “is that they’re—my depression—is wrapped up in gauze.”

I pictured a bouquet of knives, blades sticky with blood, swaddled in soft white cloth.

“Does this—does the gauze protect you from feelings that are too sharp? Too dangerous?”

“Yes…but it’s also that my depression is protected. It’s like a wound that’s been bound up, wrapped to protect it, in a bandage.”

I considered the duality: protection _from_, protection _for_. The cottony white gauze dulled the emotions from within, deadened those feelings that were too sharp and hurtfully present. At the same time the gauze padded a wound or a sore spot, shielded what was vulnerable. The knives in my mind became an oozy sore.

Nina continued. “I’m not sure I like it, not having my real, sharp, colorful emotions—but I don’t have any of the low lows, like before, but I don’t have any highs, either. Everything is just…muffled.

“But I’ll tell you what the medicine does. Before, I could be feeling fine”—she held her hand elevated, palm down, at eye level—“and then without warning, sink. Just plummet,” and she dropped her hand to her lap. “And what the medicine does, is act like an elevator—that’s how I think of it.” She held her hand up again, at her throat. “I may sink again,” and her hand dropped to her heart, paused; dropped to her belly, paused; “but instead of just dropping right to the bottom, the medicine stops me at each level. And I have a choice: get off there, or…”

“Or keep sinking?”

“Yes. But the elevator stops at each level, and I have the control to get off or keep going.”

I wondered if the elevator took Nina up, as well, but she interrupted my thoughts: “Have you ever been depressed? Have you taken medication?”

Her question prompted a flurry of brief visions: me sitting in a dark kitchen, eating sugar straight from the bag with a spoon. Getting an elaborately grotesque henna tattoo down the length of my arm and telling myself, _by the time this fades, I will feel better_. And I remembered once having an anger so fierce it left me shaking, so unable to sit and be calm that I had to run to escape it. To this day jogging is my choice prophylactic against bad moods: anger, disappointment, grief. But in the room with Nina I felt caught, and not sure that episodes of self-medication were what she wanted to hear about.

“I went through a bad couple of years in college,” I answered after a pause, “but I wasn’t diagnosed or medicated.”

“You know how sometimes it’s just too hard even to get up in the morning?”

“Sort of. But my experience was more often about anger, and fear. I felt…like there was something inside me that was so fragile that it was on the verge of breaking at any moment.”

Nina considered this. “What I find so interesting about people is their pain. I feel like I talk to someone for a while and it’s all shallow small talk, ‘blah blah blah,’ and I can’t relate. But
then they’ll mention something, and I’ll notice the pain in their eyes. And I get hooked. But I feel like the medicine takes that away from me, the ability to relate to people through my own pain. So sometimes I wonder, Is the pain really a bad thing? Or is it just real?”

She was quiet for a moment, looking away from me and out the window. Students passed by on their way to classes, their conversations faint but audible through the glass. Beyond them the trees were a riot of reds, rust, and gold; above everything the sky was the achingly clear blue of infinity.

“Did I ever tell you I used to write poetry?” Nina asked, turning again to me.

“No.”

“I did…I wrote a book of it, before. Before I started taking antidepressants,” she added. I said nothing, and looked at the line of trees and sky until the colors began to blur.

“I haven’t written any since. Something…something went away when I started taking the medicine. I just didn’t feel the pressure to write…I miss the crazy way I used to feel, like I could sit for hours and hours thinking of the perfect words, the perfect images to create…”

I waited.

“I’m not that person anymore. I feel like I don’t have anything to say, and I don’t have the words to say it, even if I did. I miss it.”

We made arrangements to meet again, after that conversation. “Siri, I’ve really loved talking to you today,” Nina had told me as she left that afternoon. “Let’s get together and continue our conversation. I’ll—would you like to see my poetry?”

I would, I said.

Another week followed, and another. I left messages on Nina’s answering machine and email account, polite, friendly, cajoling. If I caught her on the phone she was inevitably on her way out somewhere, and she would inevitably arrive home too late to call me back. Emails gathered electronic dust in an account she claimed not to check often. The writing on the wall spelled easy words in big letters, but I persevered. I wanted Nina to refuse to see me outright. At last, she did.

“Siri,” she breathed, when I had the luck to reach her by phone again. “I was hoping that if I didn’t say anything for a while, you’d just forget.” She sounded giddy, cheerful.

“I wouldn’t forget. And I’d have felt terrible if I had made you feel I had forgotten you, too.”

“I know,” Nina laughed, then sighed. “Siri, the truth is, after we last talked, I sank into a deep depression for three days.”

“I’m sorry!” I answered. I wondered about her drug-regulated elevator. Didn’t it stop her? Or did she not get off—did our talk about the poet’s feelings make her want to see how deep she could go? I remembered Nina’s attraction to darkness—her interest in the pain of other people—and was on the verge of asking her about that when she drew a breath and continued.

“It was like I fell into a hole. I just think—I’m not used to being introspective, now. It felt…dangerous. It was painful for me, for me to continue those thoughts we began talking about.”

Disappointed, I murmured something unintelligible.

“It’s like I fell down the rabbit hole.” I imagined Nina crowded in the corner of an earthen burrow, holding herself in the dark. What a contrast to the open, laughing voice on the line. But Nina meant the Rabbit Hole, and misquoted Carroll to me:
“‘Who am I?’ Alice replied. ‘I’m not sure, for I’m not the same girl I was when I got up this morning.’ That’s how I am,” Nina confided, “Not sure who I am anymore.” She quoted again. “‘My mind is a dangerous thing, into which I try not to go alone.’” She sighed.

I sighed, too.

“I have to tell you something, though.” Nina hesitated, cleared her throat. “I’ve talked to my doctor, and we’re going to try reducing my medication. I miss having feelings…I’m tired of the gauze…and I’m kinda curious about the person inside me who wrote poetry.”

“Oh. Uh.”

“But I’m afraid—of inviting that person back. I’m not sure I want to meet that person again. Will it be safe? It’s like,” and she laughed again, “meeting a boyfriend a long, long time after a bad breakup. You’re curious to see him—what will he seem like, now that you’re grown up? …But is it a good idea?”

Nina assured me that she had no objections to my making reference to our conversations in my written work. “It’s not that,” she said. “It’s just talking about my feelings and my lack of feelings—it’s too painful to explore with you. I want to just leave it alone.” But she offered, again, to show me the poetry of her pre-medicated self. And though it might be a while before I would ever lay eyes on it, I thought I would enjoy, maybe, meeting “that person.”

I thought, after we made our goodbyes and hung up, that my impressions of Nina would always be incomplete and pointillistic. Her imagery of her depressed self was vivid but borrowed from multiple scenes and sources: Was she buried, sinking, or fallen? Did her use of antidepressants make her feel in control, or merely dead?

But I wouldn’t have the chance to explore these things with Nina the way I wanted to, the way Nina was afraid to. I sulked in self-pity for a moment. And then got up to change my shoes. I pulled on a t-shirt, laced my tennies, and went to the door. Outside it was glorious, so I closed the door behind me, took a deep breath, and began to run.

**Finding a Stance**

Why look at women and depression?

Depression is one of the most popular topics of research within the field of clinical psychology, and depression in women—due to the twofold occurrence of that diagnosis among women compared to men—is perhaps the next most popular subject of investigation (Caplan, 1995; Stoppard & McMullen, 2003; Ussher, 1991). That women are diagnosed with depression twice as often as men has become a psychological truism; whether gender differences in diagnosis are “true” or an artifact of research (Eagly, 1995; McSweeny, 2004), depression is popularly seen as a women’s problem. Researchers have approached the phenomenon of depression in women from such specific contexts as hormonal sex differences and genetics (Cairney & Wade, 2002; Kaplan, 2000), social role theory (Davis, Matthews, & Twamley, 1999; Nolen-Hoeksema & Girgus, 1994), and developmental psychology (Stoppard, 2000).

More popular than any of these, however, is the investigation of a potential neurochemical, medical, understanding of depression. Much of our cultural understanding of what depression is and how it comes about is now framed in terminology taken from this medical perspective—it is a “sickness,” or a “mental illness.” This has resulted in a cultural narrative that was first given voice by psychopharmaceutical companies, the FDA, and the medical profession.

The cultural understanding of depression as a medical problem was formed as part of the larger phenomenon of the medicalization of mental and emotional issues that began in the 1960s.
Healy (1997) described the birth of medicalization in the present era as a result of the movement to promote the specificity of drugs through empirical research and a “bacteriological understanding” of what caused disease. While this model easily fit physical illnesses such as pneumonia and diabetes, Healy argued, the development of a similar catechism for mental “illness” necessitated the development of a narrative informed by the empirical, physical evidence of MRI scans and similar laboratory-based investigations.

The supremacy of this medicalized narrative has meant that the most popular current method of investigating depression is through empirical studies of antidepressant response: What does depression do when you drug it? The preponderance of this research has entrenched an understanding of depression as a straightforward story of a brain chemistry problem and a pharmaceutical fix. Currently, this medicalized narrative is voiced in the popular media, in advertising, and interpersonally in the arenas of health care, the professional world, and private life.

I was troubled by the cultural and academic popularity of the story of women’s depression as a condition of faulty brain chemistry. When looked at in light of gender differences in diagnosis, this seemed to put implicit blame on women’s own bodies as the source of their greater trouble. I wondered if this was the most salient context in which to understand women’s experience of depression, and so I looked at what the dominant body of research had to say about women, depression, and antidepressant use.

**Empirical Studies of Depression and Antidepressant Use: Context of a Cultural Narrative**

In the current literature, most studies of antidepressant use are quantitative and almost singularly focused on the measurement of drug effectiveness in reducing certain predetermined symptoms, most of which appear as criteria in such non-diagnostic screening measures as the Beck Depression Inventory (BDI) and the Hamilton Depression Rating Scale (HAM-D). Studies using these criteria look for some evidence of “treatment response,” when a consumer of antidepressants lowers her score by 50% on an inventory of chosen symptoms (DeLima, Hotoph, & Wessely, 1999; Kelsey, 2001). The gold standard of this research looks for instances of “complete remission,” wherein those treated with antidepressants reduce their score on a symptom inventory to a level comparable to non-depressed individuals (Kelsey, 2001). These clinical studies pit active medications against placebos (Beasley, Nilsson, Koke, & Gonzales, 2000; DeLima et al., 1999; Thase, Entsuah, & Rudolph, 2001) and against each other (MacGillivray, Arrol, Hatcher, Ogston, et al., 2003; Thase et al., 2001). Most published studies show both different antidepressants and placebo use are associated with changes in and remission of symptoms (Kunz, Entsuah, Lei, et al., 2000a; Thase et al., 2001) and that, for many people, depressive symptoms came back at some point after treatment for consumers both of antidepressants and of placebos (Kunz, Entsuah, Lei, et al., 2000b).

The message of the medicalized narrative is that the proper response to the experience of depression is to use medication until all symptoms are gone or, as a precautionary measure, to use it forever so symptoms won’t return. But if this was so—if even possible—will depression really be over? The lack of universal response to pharmaceutical intervention may suggest, also, that something will continue to plague some unhappy people no matter what chemical is consumed in the name of treatment. The medicalized narrative, then, does not tell the whole story of women’s experiences of depression.
Looking for New Ways to Tell the Story: The Feminist Narrative

I found company in my discomfiture with the limitations of the medicalized narrative in the discourse of feminist researchers in psychology, sociology, ethnography, and other fields (Ballou & Brown, 2002; Caplan, 1995). To feminist researchers, studies like the above tell us that antidepressant medications have an effect on depressive symptoms. But what they also tell us is that, despite this effect, they don’t cure depressed people, or bring them to a state where nothing is wrong. Treatment—or reduction—of symptoms is not, in the end, treatment of the whole problem; for despite the relief from the symptoms, many depressed people still considered themselves depressed (Kelsey, 2001; Thase et al., 2001).

The feelings of depression and the subsequent changes wrought by antidepressant use were qualitatively researched by Haslam, Brown, Atkinson, and Haslam (2004). Seeking to assess the impact of medication on people’s working life, the researchers interviewed nine focus groups of sufferers of anxiety and depression about their mental-health history and their experiences with psychopharmaceuticals. With antidepressant usage, many participants reported feeling cut off or disembodied from their emotions: “I just felt like I was behind a screen in my head all the time…like there was a fog behind my eyes,” and “When I was on Prozac…it’s like there’s a wall there, you can see what you’re doing…but you just feel distant…dislocated from everything” (Haslam et al., 2004, p. 209).

In their 2003 study of women and depression, Stoppard and Gammell examined the themes of medicalization and empowerment in women’s antidepressant treatment experiences. Interviewing nine women who had received diagnoses of depression and prescriptions for antidepressant medication, they analyzed the women’s stories of their experiences for evidence that the women did, or had come to, understand their depression as a medical problem as a result of their medical treatment, and if this understanding was as disempowering as feminist theorists have previously surmised (Greenspan, 1983; Worell & Gammell, 2003). Stoppard and Gammell found all the women understood their depression to be a medical problem with brain chemistry, usually due to the explanation given them by their physicians. Though the women did not perceive themselves to be disempowered by their treatment experiences, the life changes they made and described as attempts to cope with their depression were not changes that would be seen as empowering from a feminist standpoint, including leaving or curtailing their employment and dropping out of school. The authors argued that the women, having come to a medicalized understanding of their depression, tended to see themselves as the passive and thus disempowered sufferers of a disease over which they had little control and which could disrupt their lives in the future.

Becoming familiar with studies like the above secured my interest in the phenomenon of women coming to embrace the culturally dominant, medicalized understanding of their depression when they accept chemical antidepressant treatment for their distress. I wanted to know what role this medicalized narrative would take when women spun their own stories of depression. I worried that acceptance of this culturally powerful narrative of medicalization would overwhelm the threads of disempowerment in their lives, and that women might neglect to recognize these threads as part of their stories—and, consequently, might neglect to see their own disempowerment as an issue to be considered in the context of depression, too. To begin to get at women’s experiences, I would ask them: How do you make sense of your depression? And how have you come to understand what taking antidepressants means to you?
I looked for women to talk to. In the interest of discovering a diverse array of voices (Brabeck & Ting, 2000; hooks, 1984), I advertised over a variety of neighborhoods in this area, including rural and urban, affluent and impoverished. I put up my flyers in pharmacies, community health centers, grocery stores, and post offices (see Appendix A), describing my interest in women’s experiences and offering a little remuneration in recognition of the value of their time.

While I waited, I settled on the ethics and procedures that would inform my exploration. I had already decided on a feminist ethic as my guide, though I needed to clarify what that would mean for me in my formulation of questions, relationship to the research and participants, and the eventual presentation of my work. The logical and attractive methodological counterpart of a feminist research ethic would be, I decided, the investigative procedures and interpretive processes of narrative research. To these, then, I turned my attention.

Feminist Research

I had been aware that feminist theorists, despite their diversity of interests and orientations (Worell & Remer, 2003) had identified a number of common points of criticism with a disease-model understanding of depression in women. One of these issues was the potentially women-blaming problem of medicalization, which posits that depression emerges from a woman’s faulty brain- or body-chemistry, placing the cause of her troubles within her and ignoring the possible detrimental effects of a distressing environment (Caplan, 1995; Stoppard, 2003; Stoppard & Gammell, 2000). Attendant to this concern is the methodology that supports medicalized research; feminists have looked with a critical eye at certain features of the traditional positivist, empirical methods favored by what is often termed the “mainstream” of the research community (Fonow & Cook, 1991; Kirsch, 1999; Ramazanoğlu & Holland, 2002).

Mainstream psychological research concerns itself with the clinical tenets of science, embodied by the ideal of the objective, unbiased researcher conducting investigations from a remove guaranteed to prevent contamination of the research site. Objectivity, the notion of a bias-free stance, the use of standardized measures to collect and generalize experiences, and the notion of research having its own intrinsic value contribute to a body of research that, as some feminist scholars point out, reflects an artificial view of the social moment under investigation and lacks the benefit of promoting social change, as well. Feminist researchers question and reject the notion that it is only these mainstream practices that give research its so-called “rigor” or value. Feminist researchers work to cultivate an investigative custom that addresses the estrangement of researcher and participant, seeks to effect empowering social change, and defines the value of consequent findings around the success of those attempts at empowerment (Christians, 2000).

Presence of the Researcher: Objectivity Versus Acknowledgment of Bias

One of the foremost convictions of feminist research is that true objectivity—the essential non-presentation of the researcher—is a methodological chimera (Lincoln & Guba, 2000; Olesen, 2000). Intended to produce value-free research, objectivity necessitates the stance of an invisible researcher who is called upon to create a sense of disinterested uninvolvment through a pretense of limited participation in the creation of information (Christians, 2000). Invisibility is also attempted in the dissemination of information, in which the voice of the researcher is disguised,
self-less, and ethereal: a third-person remove intended to suggest a neutral observation by an impartial observer (Massey, 2003).

Feminist researchers realize that with the subjective presence of the researcher comes the inevitable and undeniable presence of her bias and values (Kirsch, 1999; Naples, 2003). A researcher displays her bias in the questions she asks (and those she neglects to ask), the measures she uses to capture an experience (and those she forgoes), and the experiences she seeks to capture (and those she ignores) (Fonow & Cook, 1991; Olesen, 2000). Feminist criticism of the notion of any research being truly objective or “value-free” has lead to the practice of reflexivity (Olesen, 2000; Westkott, 1990/1979), in which the researcher continually examines her own values and the influence they have on the construction and interpretation of her research. “Value-fair” research is another feminist concession to the importance of acknowledging one’s own values in the research process; the researcher explores the possible impact that values other than her own (for example, those of her participants or her readers) could have on the shaping and understanding of her investigations (Fonow & Cook, 1991).

While reflexivity and acknowledgement do not erase the bias of the researcher, they do allow for another layer of critical interpretation by the eventual reader, the participant in the investigative study, and the researcher herself. For example, in the text above relating Nina’s story of her antidepressant use I attempted to be transparent about my own attitudes about and reactions to what she told me. By portraying these thoughts as narrative asides or internal monologues, I could be present in the text, reminding the reader that all words are understood through the filter of one’s own bias. The reader, then, is empowered to make her own sense both of Nina’s words, my reactions, and her own positioned response to what she reads.

I took stock of my own bias at the beginning of the project: I suspected that when women who were taking antidepressants told their stories of experiences with depression, the cultural narrative of medicalization would supersede the threads of other narratives in their tales, including narratives of disempowerment that might otherwise have figured more prominently in their conceptualization of being depressed. I worried that when women pushed aside the narrative threads of disempowerment as unimportant to their experience of being depressed, their stories would show an acceptance of these distressing circumstances, their amelioration irrelevant to the idea of having a better life.

I wanted to acknowledge and record the position from which I began so that I could be aware of how it might affect my relationship with the women I talked to. I realized, too, that it was equally likely my relationship with the women would affect my bias, and I wanted to be able to keep track of my own change in understanding over time. With that in mind, I knew I would not showcase only those stories that supported my bias while suppressing those that pointed in a different direction. The goal was to illustrate the multiple truths in how women come to make sense of their experiences with taking antidepressants for their depression; all tales would satisfy that end.

Questions of Power: Generation and Distribution

Another important piece of feminist research is the principle that questions of power must be addressed, including: Who has it, how can it be shared, how does its imbalance affect the story being told, and who else could benefit from it?

One of the first things I had to do to attend to these concerns was through the recruitment and selection of participants. In the years since the first wave of feminism, post- and afra- and
other feminists have criticized the original feminist movement itself for assuming that the experiences of white, upper-class women could speak to the oppressive experiences of all women (Brabeck & Ting, 2000; Olesen, 2000), and stressed the necessity of seeking a diverse array of experiences in any research investigations (Fonow & Cook, 1991; hooks, 1984; Kirsch, 1999; Ramazanoğlu & Holland, 2002). Seeking this diversity gives power to voices that at other times may have been unheard and acknowledges the different ways through which women may have suffered from a power imbalance, including, for example, her age, her physical health, her professional choices, and her sexual life.

The next step in the assessment of power was to weigh it in my relationship with the women I met. Because I had that relationship—I was not, after all, maintaining a traditional objective reserve—I had to be aware of its potential for imbalance, and redress that imbalance if I could. If I recognized that I must hold a position no more privileged than the participant’s, there were a number means to respect that equality.

One was to use the women’s own words to portray their stories, an approach suggested by the feminist ethic which “affirms, attends to, and authorizes the experience of the [women] in their own voices” (Brabeck & Brown, 2002, p. 32). This skirts the danger of neglecting or distorting unique aspects of women’s experiences when translating them into the generic terminology of standardized measures (Gergen, 2000; Kirsch, 1999; Stoppard, 2000). To that end, given each woman’s permission, I audio- and videotaped our conversations for the purposes of later transcription (see Appendices B and C).

Sometimes, the conversations took a direction unanticipated by me. I had scheduled a series of semi-structured interviews (two to three per participant) of 60-90 minutes in length, loosely based on a list of questions addressing the circumstances of her depression, her diagnosis and beginning of treatment, affective changes during chemical treatment, personal hopes for the future, and general understanding of depression and the action of antidepressants (see Appendix D). I found that the space and freedom offered by the structure of the interviews encouraged some of the women to take advantage of the chance to tell their stories as they deemed appropriate. Comparing those questions I planned to ask to the material that eventually emerged in each narrative provides yet another layer of interpretation.

After collecting and analyzing the women’s personal stories, the feminist ethic of collaboration suggested a meeting with each participant in order to assure we had captured what she felt was her true story (Fonow & Cook, 1991; Kirsch, 1999; Olesen, 2000). Honoring each woman’s reaction to my interpretation of her story served to equalize the power in the presentation of the research results, for even if we disagreed, our opposing viewpoints could be presented together (Christians, 2000).

An overarching consideration of power resides in the question: Who has the power to define what depression is, and who has the power to define what is “better”? Who decides that certain symptoms mean depression, and their absence, healing? Usually it is doctors, and not their patients, who have the power to define (diagnose) depression, and it certainly rests upon doctors to decide if a woman’s experience satisfies the definition well enough for him to decide to help her. A question to consider when scrutinizing power in this context is: Do women have the power to define for themselves what is sickness and what is health, and how might their identification of these things be circumscribed by the culture and society to which they belong? Who decides what “normalcy” is? By engaging the women on these topics, I could find what sense they made about the concepts of sickness and health, “better” and “normal.”
Feminist activism has always been associated with consciousness raising, of bringing to greater awareness the problems of individuals and groups. Consciousness raising can also mean increasing the awareness of an individual—a woman’s about the circumstances of her disempowerment, say, or a researcher’s about structures other than disempowerment and medicalization about which women can frame stories of their distress. But the greatest promise has always been the possibility of reaching and igniting a wider audience. For as social awareness increases so does the potential for social change; the more people who know and care about a problem, the greater the likelihood of activism, of people agitating for a difference in the accepted way of being.

How would I reach this wider audience? Research is traditionally distributed to and for those who do it themselves; that is, much academic research takes the form of preaching to the choir. I did not want to take this approach for a number of reasons: I felt it would alienate the non-academic women who had helped me and were sincerely interested in the final outcome of their sharing themselves with me, and I worried that couching my exploration in the terms and form of traditional academic research would confine it to the ivory tower. And even in that lofty tower, there are rooms of academics who do not know how to talk to each other, so that I could fail to engage much of even that small sample. How, then, to speak to everyone?

I chose to couch my research in a context accessible and interesting to a wider audience, including academics unfamiliar with the narrative genre, interested non-academics, and the participants themselves. I did not wish privilege psychology academics or distance others, including those who were involved in co-creating the research in the first place, so I needed to find an inclusive form of research write-up to match the inclusiveness of its creation. Thus I settled on writing the women’s stories in a creative-nonfiction style (Richardson, 2000) which seeks to help the reader understand a phenomenon by vicarious immersion in the experience. A sense of believable realism, or verisimilitude, is the qualitative writer’s validity and was the tool with which I attempted to create this immersion (Denzin, 2001). I hoped this vicarious experience would fill the gaps in understanding left by traditional modes of research, would give color, shape, and texture to further understanding of women’s depression and antidepressant use.

**Narrative Research**

Narrative research means more than putting all the research data in the form of stories. Many of its ethics overlap with the ethics of the feminist researcher; other principles evolve from the goal of enriching general understanding of a phenomenon: in this case, that of women consuming antidepressants. Having this goal dictated the kind of questions I would want to ask, for the answers I would elicit should be those that expanded understanding rather than refined or narrowed it.

The nature of holding a bias—and its peril—is that it suggests and encourages asking why questions, as though the relationship framed by the bias really exists: Why do antidepressants disempower women? This is a question that implies a causal relationship, which is problematic in itself, for investigating a causal relationship narrows the focus of understanding a phenomenon by restricting that understanding to “true” or “false” experiences, confining their role to data in support of or contrary to a theory or hypothesis.
Narrative investigation, unlike quantitative investigation, does not posit a hypothesis, and narrative data are not gathered toward the end of proving or disproving a theory. While scientific exploration is devoted to the analysis of cause-and-effect and seeks to refine its understanding of a given phenomenon through ruling out a series of possibilities, narrative research devotes itself to broaden its understanding by deeply exploring different experiences of a given phenomenon. Recognizing my bias as my own prepared me to ask and accept the answers to a how question instead. Asking the question “How do you make sense of your experience with depression and taking antidepressants?” allowed for those multiple truths which contributed to an enriched description of the phenomenon of women taking antidepressants.

Enriching Understanding: Context, Description, and Interpretation

Narrative research depends on context: The phenomenon of women taking antidepressants, and the women themselves, existed in contexts that had to be acknowledged before meaningful exploration or interpretation could begin.

My contextualizing of the phenomenon necessitated examining and deconstructing how it has been studied, presented, and accepted in other research (Denzin, 2001). In my above deconstructing of women and depression, I looked at how the dominant research had developed a medicalized narrative in this culture and how it had influenced how we think about women, depression, and the consumption of antidepressant drugs. This gave a context for what I came to call the cultural or master narrative of medicalization and provided a screen against which other narratives—feminist, personal—could be contrasted.

The personal context of each woman’s life was examined through the use of a critical progressive-regressive method, called the “critical interpretive method” by Denzin (2001). Using this method allowed me to place each woman’s experiences in the context of her time. Taking a regressive look at the culture each woman grew up in—in which she first came to understand herself as a depressed woman and an antidepressant user, including the social and cultural conditions that moved her to make the decision to use antidepressants in the first place—was used to bring to light how a woman may have arrived at her own understanding of antidepressant use. I then used a progressive analysis to examine each woman’s hopes and thoughts for her future as they were inevitably circumscribed by her culturally informed understanding of herself, the value of her continued recovery, and what kind of life she had a right to expect.

Including details of personal context in the narrative texts begged for more description than demographic statistics. Denzin (2001) advocated inclusion in the text a context of sensory details, emotional cues, and situational elements. Called “thick description,” these are the features that help establish an atmosphere conducive to vicarious experience and various interpretations, the “verisimilitude” mentioned above. Some of this rich qualitative data were furnished when, taking a cue from Denzin’s (1997) criticism of the purely verbal text, I included contexts of intonation, gesture, and expression as integral parts of the participants’ discourse and my reactions to them. Without these cues, printed speech can lose much of its meaning and is more vulnerable to the uninformed projections and assumptions of the researcher and the eventual reader (Denzin, 1997, 2000; Olesen, 2000).
Contrapuntal Narrative

It became clear that with thick description, thick interpretation, feminist ethics, narrative considerations, and the presence and celebration of multiple voices there could be no single narrative in any woman’s story. Each woman’s own narrative would—by the nature of how she told it, how I heard it, and how we portrayed it—contain a number of narrative threads. I decided that while the contextual description could allow for the definition of any number of narrative lines, I would concentrate on the contraposition of three different narratives: the medicalized “master” narrative, the feminist narrative of disempowerment, and, not least important, each woman’s personal narrative of her own understanding of depression.

Medicalization: The Master Narrative

I have described in previous pages the master narrative of medicalization, the culturally prominent understanding of depression that piqued my concern for this exploration in the first place. I took the opportunity to listen for this master narrative in the stories women told of their own depression. I wondered if this might come out in a straightforward refrain, with women parroting the kinds of neurochemical explanations of depression that have become so widely available from television programs, pamphlets on mental illness, and promotional advertisements in women’s magazines.¹ Perhaps the medicalized narrative would be a marginalized thread of a woman’s story, implicitly accepted by virtue of the woman’s using antidepressants, but unimportant to her overall understanding of her depression. The issue of how important a medical understanding of depression was to each woman and her conception of why she was depressed, and what she might hope for in her life, was something I considered when listening to these stories.

Disempowerment: The Feminist Narrative

My own perspective, I decided, would appear as a feminist narrative, a reflexive thread in the stories the women told me and which I recreated here. I used this narrative thread to trace my concern with the contexts of disempowerment identified by feminists as being problematic in depression, knowing that my concern would surely shape how I heard and reacted to the women’s stories.

Some of the contexts I expected, and found, in the women’s stories involved devaluation in the professional world. Some of these women held low paying jobs, positions often held in little esteem (and compensated accordingly) because they were traditionally “women’s work”—such as nursing, teaching, administrative duties, and work in the service industries—or because the jobs were considered unskilled labor. Other contexts included a lack of opportunities for advancement, often as a result of having to choose between continuous employment and taking time off to raise children.

¹ I received one such advertisement recently from a colleague of mine. It featured the familiar and popular Zoloft family of white blob faces, starring the mother blob and her small child blob. The mother blob described feeling listless and tired all the time and suffered a shock when her small bloblet complained “Mom, you aren’t fun anymore.” Mom went posthaste to the doctor and was prescribed Zoloft for her ailment, and the strip concluded with the tagline, “After all, you have only once chance to bring up your children.” Unfortunately, I don’t know where this ad came from as the page was torn from a magazine and otherwise unidentified.
Another potential context I kept my ear out for was women’s experiences of inequitable relationships with significant others. These experiences ranged from abusive relationships, including instances of physical and emotional abuse, to living situations that favored one partner over the other—like Nina’s move across the country for her husband’s job at the expense of her own—to the unequal distribution of domestic labor, and to other inequalities, including material, financial, and emotional, that could be sources of disenchantment in a relationship.

While contexts of disempowerment in the professional and interpersonal worlds were easier to define and understand (“I get why I’m upset about my job,” one woman remarked), troubling contexts shaped by social expectations and limitations were more elusive and difficult to capture, often woven matter-of-factly into women’s narratives and not frequently identified as unfair circumstances, but rather seen as “just what I had to do.” These contexts included the stress of upholding multiple roles, such as the so-called “second shift” of the woman who works full-time and also does the majority of the housework or comes home to the duties of the main caregiver to children or elderly relatives (Hochschild & Machung, 1989).

I projected four possible themes under which disempowering circumstances were likely to fall: inequitable relationships, workplace devaluation, role stresses, and traditional stresses (Worrell & Remer, 2003). These situations may not have been perceived by the participant as disempowering, but they served as a framework for me to situate the current cultural and societal context that I had considered as part of the progressive-regressive critical method described above. Identifying these themes, too, helped me situate my own bias in relation to each woman’s story as I could use them to recognize the stance I was likely to take in trying to make my own sense of her narrative.

This Was My Life: The Personal Narrative

The greatest part of each woman’s story was her personal narrative of how she came to be depressed, how she decided to try to get better, the role of the antidepressant in getting better, and what her idea of “better” even was. Parts of these stories included elements of the master narrative, for each woman had accepted this narrative enough to receive medical antidepressant treatment. And parts of these stories incorporated elements of the narrative of disempowerment, for most women identified some reasons other than medical for their unhappiness: the stress of raising children alone, the chagrin of working in undervalued jobs, the horror of living in an abusive relationship, or the drain of performing multiple roles (Greenspan, 1983; Laidlaw & Malmo 1990; Stoppard, 2000; Worrell & Remer, 2003). My task was to recognize these threads as they came up, and then put them aside in order to identify that thread I had not anticipated, weighing its heft and noting its color and texture, getting to know it well enough so I could trace it in the whole design, noting how it wove elements together and where it set them apart.

Construction of the Texts: Data, Interpretation, and Imagination

The construction of the final narratives was the bulk of the research work, involving the collection, interpretation, and presentation of the narrative data supplied by the interviews. The first step in creating the narratives was converting the raw data of the interview into source text for the final narrative. Some of this text came directly from the participant, as in the case of written email communication to me. I reproduced this material verbatim in the narratives with no
The transcribed interviews were turned into “scripts,” or working transcripts. In this step I attempted to reproduce in text the cadence of the participant’s speech and recorded visual details of our interaction and environment using cues from the video recordings of the interviews. It was at this point that I incorporated my field notes from the interviews into the texts, including my initial impressions of the participant and our interaction.

Because each hour of interview generated some 20 to 40 pages of transcript, and because the course of the conversations meandered according to the will and interest of the researcher and participant, it was necessary to read and re-read each set of interviews to begin to gain a sense of important themes and an idea of timeline. Transcript material relating to these themes and an initial sense of narrative chronology were then extracted to form a preliminary draft of the narrative. This rough narrative was presented to each participant, her corrections to chronological or factual details made and her response to the thematic interpretation recorded.

The final narratives were then constructed from the rough outline of the initial drafts. In these, the selected original data from the transcripts appears unaltered in the form of speech, both in quotes (Lila’s story) and when otherwise indicated that the participant or I was speaking (Kylie’s story). Original transcript material was used in the construction of Jenny’s written journal entries, with sections of her transcribed interviews sorted by theme (e.g., family relationships, diagnosis) and the sentences that referred to those quoted verbatim in text. Other than that sorting and the insertion of an occasional sentence in reference to writing in a journal (e.g., “I’ll write more later”) in order to transition sections, all original verbal material was unedited. Avery’s story was presented as a combination of her actual speech and her private thoughts; all this material, save for one explanatory sentence (“How long have I been spacing out?”), was taken directly from the transcript. In all the stories, details of scenes where I was present were reported as faithfully as possible. Scenes that took place outside my experience, whether described to me by the participant or imagined by me, can be read as artifacts of my invention that have been approved by the participants.

The act of creating the final narratives was the culmination of the analysis: an effect of, and intended to create, what Denzin (2001) called “thick interpretation.” Thick interpretation is the desired result of thick description, and the rich understanding this implies occurs, ideally, in the women who frame their experiences for me, in my own interpretive reframing as a researcher, and in the eventual reconceptualization by the immersed and involved reader. An ideal vehicle for this kind of interpretation is performance writing, a style of presentation that “shows, rather than tells…enacting what it describes” (Denzin, 2001, p. 19). Showing, rather than telling, each woman’s experience suggested to me the use of different styles of written performance for different stories. Toward this end I attempted to create differently voiced narratives that showed, for example, my intrusive presence in Lila’s story, the distanced, almost numbed remove of Kylie’s experience while taking medication, Jenny’s conflict between almost defensive shyness and a desire to be heard, and Avery’s calculated expression of outward speech and reticence of internal thought. I hoped that writing in this manner would help the reader feel immersed in each woman’s experience rather than viewing it as an outside spectator, and would allow for a more intimate experience with and interpretation of each narrative.
Lila sat at her desk. Her old computer was slow to come to life, and while it whirred and muttered to itself Lila wheeled her chair into a more comfortable position. She arranged her bad arm in her lap where it would be less likely to fall asleep, not that it being numb would change anything. Still useless. She took the mouse and clicked impatiently at the screen fuzzing to life, clicked into action the modem. Ignoring the electronic screeches and static roar—her husband had always thought that that noise meant they were being spied on, how ridiculous—Lila fished out a small scrap of paper from her breast pocket. She smoothed it on the desk, and squinted at it. Tiny print. Carefully, she pecked at the keys, checking the slip frequently to be sure of her spelling. Then, one-handed, she began to type.

From: Lila Thompson Lilathompson@in.com
Sent: Tuesday, February 8, 2005 2:54 PM
To: womendepression@hotmail.com
Subject: Info

seen your info at walmart, interested in your program, i am 72, had stroke soon be 5 years, raised 2 adopted kids, lot of problems with them, i worked for years to be away from them, dr. advice, both had serious health problems and still do, hubby of 52 years has had by pass surgery, fine on that part, but arthritis in both hips now, dementia besides, my son was recently in coma for 7 weeks, never knew why but a bad diabetic, daughter divorced after 22 years and always lived beside us on our farm, shortly after married man from on internet , was 2 years ago, now 3 hours from us, we raised her 3 kids, but divorce bitter, she has one son living with her that we raised completely, oldest son still lives next to us, her daughter lives with her dad, married again too, we have gave and done for all for all their lives, can't now but expect us to yet, son's kids and grand daughter we see about once a year, had them for years every weekend after his divorce 22 years ago,

just recently hubby has not been able to do much of anything, cares for me, but i do most can for myself, wheelchair bound most time at home but can walk with cane, no use of left hand or arm,

big problem is daughter and hubby work the system, anything for free, son lost job on his arrest year ago, no job, no money, but he has lived most of years with us, never helps do anything, is on medicaid now, sisters idea, trying for disability too, he is more than able to work, but he went to live with her, now trying to get anything and everything free he can, got food stamps here at last, we ran very short last few months helping him, but not allowed to touch his food,

i am on 3 antidepressants, been for years, long as worked i could handle, but confined to home as can't drive vehicles we have, i just about go nuts, went to therapy for counseling, helped but she had to quit, didn't want to start over, i cry alot, horrible temper, times hard to live with, but is reckon, chemical imbalance of my brain causing lot now,
my faith and my good hubby is all keeps me going, i have faith to keep me going too, Lord has been good to me but lot of problems too, now when we need kids most, don't want to hear our problems or help us, no gratitude at all, we have gave our life to them and now wondering why, all waiting for is us to die to get our farm, but if things don't change may get dollar and nothing else, we have everything paid for, burial insurance and trust that they won't have to pay much, hubby won't sell, i would like to, but grandson here wants but can't afford, damned if we do and damned if we don't,

let me know what your all about, i belong to stroke group on line that helps a lot, but your flyer just caught my eye, so if can let me know things this way, appreciate if would,

thanks,
Lila A. Thompson

February 15, 2005

The road to Indiana was pretty, winding through small towns and past dormant fields the winter grey-brown color of deer. It was an unseasonably warm day for February, with the sun shining bright gold, and purple crocus were beginning to peek up through dry grass on the side of the road. Nice, I thought, and I didn’t mind that I had to take my time on the drive. It gave me time to think about Lila, and to wonder how she would talk about her depression. I tried to imagine her plight: in a wheelchair, unable to get around much, and facing increasing demands on her caretaking by both her and her husband’s infirmities and advancing age. Her farm—and something stirred in me as I looked at those quietly beautiful fields—wouldn’t bring enough money, likely, to pay for her care in a facility in town. And it didn’t sound like Lila wanted to leave, anyway.

I had to frequently consult the directions Lila had sent (“go left at the old broken gas pump,” “make sure you pass the county line then look for the new blacktop road on your right”) in an effort to not get lost. In this area, unmarked roads were familiar to locals and probably infrequently traveled by visitors such as me. As much as I appreciated the scenery, I didn’t enjoy the idea of missing a turn and driving past those dead cornfields for hours so I watched carefully for Lila’s landmarks and was in time rewarded with the right address.

I pulled up before Lila’s farmhouse, a small, one-level ranch with a mildewed trailer home parked adjacent. An older American car of the wide and boatish variety—Lila’s car, I guessed—was parked next to a muddy Jeep that likely belonged to the grandson living next door. The front lawn bore evidence of dogs, their presence corroborated by frantic yelps when I walked up the path. Given their welcome, I wasn’t sure I needed to ring the bell; sure enough, there Lila was, holding open the door behind the screen. “Hello,” she called to me, and then presumably to the dogs, “Shut up already. You sit down and be good.”

Lila was seated in her wheelchair—beady-eyed wiener dogs peeped at me from behind it—and nodded unsmilingly at me when I offered my hand and said hello. “It’s nice to meetcha,” she sighed. “Well, here we are. Would you like anything? I think we’ll be comfey in the kitchen.” She turned and preceded me into that room, addressing me over her shoulder as she went. “I hope you don’t mind dogs.”
“It’s OK. I like ’em alright.”

Lila shrugged, glanced at me then looked away. “Well, then, what d’ya want to know about?” She settled back in her chair, a large woman even seated. She looked like she’d be a head taller than me standing up, and her body was both bulk and flab underneath the sweatsuit she wore. Her hair was steely, pulled back in a clip, and behind her thick lenses her eyes finally looked straight into mine. She didn’t have old-looking eyes, I thought.

“Uh, when did you first start feeling depressed? Can you tell me a little about what was going on then in your life?” This question seemed to pull the cork from some pent-up pressure in Lila, and at once I understood the streaming narrative of her email to me—she spoke, too, with no full stops.

“I first got bad back when my son was adopted—he had lots of problems, got him as an eight week old baby, a stubborn child—I like to say I graduated twice getting him through high school, and I guess today he’d be called ADD or something—we adopted his sister three and a half years later, she was two weeks old, and she had her problems, too—we quit our jobs—we were all working at the shoe factory—we quit to farm with the kids, but it got so bad with them that I went back to work to get away from them, and to get some extra money—my son was always in an’ outta trouble, he went AWOL from the Navy, always livin’ off somebody else, he was just arrested and now he’s on probation—he’s had a tumor, bleedin’ in the brain, and diabetic, besides, but still that’s no excuse for now, he’s fine but he won’t work…”

My head started to spin with the glut of information. I looked down at the dog, snoring moistly in my lap, and tried to gather my thoughts. Before I could, the drone of Lila’s recital paused, and I looked up. Her face had turned deep red, and her eyes screwed up against tears.

“So many times in his life he’s had a second chance!” Lila sobbed. “But he won’t work—he just lives off everyone!”

I waited, not knowing what to say. How did we get to be talking about her son’s messed-up life? I wanted to talk about Lila’s depression. She continued to cry, loudly. I shifted in my seat and looked around the kitchen, neat but for a clutter of prescription bottles and sample packs of different medicines and remedies. At last Lila’s gasping cries subsided, and I thought I could try a different tack.

“Can you tell me a little about what’s it’s been like to be in a wheelchair?”

Lila’s voice dropped back to its normal volume. “I had aneurysm surgery an’ ended up like this,” she motioned to her wheelchair. “It was one year after I retired—I woke up and I couldn’t use my left side—I can move my shoulder, now—with a lot of effort an’ pain I can do most for myself ’cept put a brassiere on, but I can go without that if I have to—I have arthritis in every bone of my body—so I can walk with canes, if I absolutely have to, but I have to have my husband help me get in and out of the car and he’s getting so’s he can’t lift me—I’m not a small woman, you know—I wish we could get a van, for the mobility, but it just costs too much and we don’t have the money—our Social Security and our pensions aren’t enough to pay for insurance and health care—by the time you pay your bills every month there’s nothing left—I get free medicines from my doctors, though, that’s who gives me the antidepressants and I’m on something for anxiety, too—they give me free samples of things and I get by—but now my husband’s got dementia and the stuff for that is real expensive—he could go for cheap down at the VA hospital, but it’s too hard for us to get there…” Lila paused at last, her face darkened again, and she bawled. “I feel now we’re so deserted—all our lives we took care of them—done without to give to them—I raised them kids with no water in the house and no bathroom—we
had to cut wood for the furnace—and now they won’t do a thing for us—we’ve always had money problems, mostly from giving to them.”

The kids again, I huffed to myself, as Lila wept. “What happens when you really need help?”

“They don’t do nothin’” Lila sniffed. “So I cuss, and I holler, and I scream—take my medicine—cry—I guess I got a bad temper and I always feel like I’m going to come unglued—I’m very outspoken, you see, and if I don’t like somethin’ I’ll tell you about it—that’s how I keep from explodin’.” Her tears streaked her face and dappled her shirt. “But my kids—we raised them in church—why don’t they do better?”

When I left that afternoon, I couldn’t get the raw wail of Lila’s voice out of my head. She seemed barely in control; I wondered what she would be like without her two antidepressants and her anxiolytic. I imagined that the tears and rage that bubbled just beneath her surface would boil out of her. She would dissolve, I suspected. And why not? From what I understood, she barely had enough money to get by, and the relief she could get depended on the charity of her doctors. Even if she could afford counseling, she wouldn’t be able to get to it regularly—her grandson next door seemed to be able to help with buying groceries and running occasional errands, but his work schedule didn’t seem to allow him the leeway to care for his grandparents on a more demanding, regular schedule. And Lila seemed to support him as much or more as he helped her, allowing him to live rent-free on her property, making sure he had the food and gas money he needed. Lila didn’t seem to mind this—she was grateful for his help, but didn’t dwell on it. Nor did she dwell on her disabilities; after cataloguing her and her husband’s many ailments, she shrugged and changed the subject. She didn’t seem upset about her lack of money, either, or about the diminishment of her farm day by day—she had merely shrugged again when she described how she’d had to sell off her livestock hog by cow a few years ago, unable at last to keep up anymore with the work that had been her family’s livelihood for so long. She didn’t complain about her age, or fret about death.

Not only did Lila not talk about the hard circumstances I had expected her to, but I’d a hard time, I thought, getting Lila to talk about herself and about her depression at all. The entire afternoon, I recalled with frustration, had been taken up by a confusing and convoluted recital of the troubles her kids were having, and my brain hurt with the effort of trying to keep track of who was who doing what wrong. I clutched the steering wheel and frowned into the distance. Maybe I couldn’t use Lila in this study after all. Maybe she wouldn’t be able to talk about using antidepressants, or about being depressed, or disabled, or poor, or old.

Maybe all she could do is cry about those kids.

One night a week or so later, though, I finally got it. I pictured Lila alone at her kitchen table, listening to the wheeze of her husband sleeping in the other room, he muttering names of people long dead who visited his dreams. She sorting her coupons one-handed, deciding what could go to her grandson, what she could use to help her daughter, what would remain for herself. Wondering when she could cadge a ride into town to use them, anyway. Waiting for the phone to ring—it works both ways, you know—to hear a voice on the other end say, “Hey mom. We thought we’d come for a visit, see how you and dad are doing. Do you need anything for the house? We’ll pick up some groceries on the way.” But tracing the silence of the receiver to the tangled cord, hanging knotted in its coils almost to the floor, to the silent wires outside, stretching across the silent yard past the fields, past the neighbors silent in the closed circles of their own families, through the silent distance to the towns beyond her imagination, where the other receivers rested in their cradles, breaking the connection. You raise kids to be good, to do
good, not just because it’s the right thing to do for them but because it is the right thing to do for a family. It shores up the foundation, makes it strong. But when you fail, you look toward the end of your life and wonder which way it will crumble, unsupported and unrepaired. You wonder what you did wrong, when you’d tried so hard to do right, by faith and by family.

My notions of Lila’s needs, of socially funded programs, mobility buses, and affordable, accessible healthcare for the rural poor, finally loosened their grip on my imagination. I saw at last that Lila expected these things only from her family, and waited in vain for their silence to be broken. I had seen her plight as a cultural failing, a neglectful act of society, but had social services suddenly become available and Lila found dinner on her table and a nurse by her husband’s bedside…would she still feel a sense of personal failing, for the family who should have been there? I finally heard the silence around Lila’s story, and I finally got it, I think. Lila, I’m sorry it took me so long to listen. I so, so apologize for my failure to hear.

Postscript: Disappointed Expectations, Looking Back, Looking Forward

When I first approached Lila and her story, I had a certain amount of knowledge about her and, consequently, certain expectations of what she would say when she talked about what mattered to her. I knew she was disabled, and expected to hear about that; I knew she was in shaky financial shape, that she was having to care for herself and her husband in their advancing age and declining health, and I expected to hear about that, too. I learned that she had early been frustrated in an expected part of a woman’s life when she found herself unable to conceive children, frustrated again when she found the role of adopted mother uncomfortable and wearying, and I thought I might hear more about these things. These events were threads of her story, but I was ultimately disappointed in my expectation that they would prove to be central to her description of her depression.

Lila grew up in a rural area, the child of farmers and a farmer herself. She graduated from high school, an achievement enough in her time, and she saw no need to further her education—“Where would I go with a college education? My family’s all here.” She grew up with the knowledge that her job was to do right by her family until she could raise her own, and dates her beginning of feeling depressed with her early failures to create the family she thought she ought to have. She was heartbroken at first by the inability of her children to conform to the life she offered them, and by her inability to suffer that nonconformity (“I went back to work to get away from them, doctor’s orders”). Her current heartbreak rested on what they had become: in her eyes, greedy leeches of social welfare programs, unable to look after themselves properly, and certainly unwilling to look after her.

When I asked Lila what life would be like if she and her husband enjoyed social welfare programs not currently available to her—free or reduced-cost vans to medical appointments and shopping centers, visits by home healthcare professionals, meals on wheels, counseling services—she only paused for a moment and said “Huh,” in an “it’d be nice to fly, too,” tone of voice. But the presence or absence of these services seemed irrelevant to her, and even when she imagined that her health, home, and husband were taken care of, she nonetheless circled back to her principal refrain, crying about her kids.

Was Lila a casualty of medicalization? Depression as a disease barely made an appearance in her story, and antidepressants themselves joined the host of other drugs she took as a matter of course, the palliative tonics of old age. What would she be like without them? “I don’t know—worse, I guess,” she replied. For her, it was beside the point. Was she
disempowered by her understanding of depression and recovery? What would she change, if she weren’t “distracted” (if she even was) by the drug? I was troubled by these questions, for what would a feminist consciousness-raising entail, in Lila’s case? That I got her exercised enough about her lack of social services so that she howled her outrage from the rural distance? I wasn’t sure that my brand of empowerment would serve Lila’s interests, and it remained that, for Lila, my point was no point indeed. But it took time for me to realize that, though the vantage from my feminist soapbox was an interesting one, it offered only one point of view. It took time for me to step down and listen to Lila’s cries, see her world through her tears. Consciousness raising, indeed, takes time.

Chagrined by my first bumbling attempts with Lila, I resolved that I would try to listen better to the next woman who told me her story, that I would allow her concept of her depression guide her telling and not attempt to shape it myself with questions sprung from my own expectations. Opportunity arose with Kylie, a 34-year-old wife and mother of a young daughter, working part-time as an administrator. She had been intrigued by my advertisement; she felt herself recovered from depression, though she still took antidepressants, and she liked to share her battles with other women so that they might learn from her experience. She was frank, and talked easily, and the details of her story slowly coalesced around three points.

Three Episodes

1. Diagnosis

After everything—after watching her best friend’s marriage choke, wither, and finally fail; after driving hours upstate several times a week for months on end, toddler daughter complaining in the backseat, to attend to her grandmother in the hometown hospital where she would ultimately wither and fail, too; after leaving that good job to instead try to be a good mom, and a good wife, and finding the script for both those roles seemingly in an unfamiliar tongue, choreographed to a score that made her feel more clumsy and unfit as she tried to dance to it; after months of watching the skin on her hands and feet crackle and peel like the rind of a roast, leaving raw, red splits to sting in the air and catch on passing surfaces, having doctor after doctor shrug and suggest hand cream to soothe a wretchedness that went beyond the roughness of palms—after all this, Kylie was still surprised to learn she was depressed.

It happened after what was supposed to be a romantic trip for two to Las Vegas. This was supposed to be a little time to escape the tension and frustration of motherhood, of trying to playact a Martha Stewart mom with no heart for the role. A little time to breathe without feeling pissed at the kid for her endless Nos and sulks, or infuriated at the husband who came home, shot her a look of contempt for not having done the dishes yet during a whole day spent at home with the child, and doing them himself in a silent way that bespoke condemnation and disgust. A little time to escape the chores that exacerbated her skin condition, the laundry that caught on her hands and tore her skin, the steroid creams she had to wincingly rinse away before she could touch her daughter, the child herself who shrank from her caress, fine hairs slicing her knuckles, saying Mommy don’t. Your hands hurt me.

The first day in Vegas a migraine arrived with her, and her swollen feet tore on the straps of her new sandals until she couldn’t walk. Her husband left her, angry, to spend the night walking the casinos. She stayed in the hotel room, swallowing room service ice cream past the lump in her throat. For some days the pain persisted. Only one day, their last day, was good. She and her husband walked all around town, had a good meal, gawked in shop windows at the
outrageous and the overpriced. At the end, her husband said, All I really wanted was a chance to forget what was wrong with you for a little while. Her enjoyment dissolved and the anger flooded back. She said, What did you want me to do? Leave my feet at home?

Back in town, she dragged her husband to the therapist she had been secretly visiting for couples counseling. It was time to work to make things right. If the marriage was failing, both had to work to save it; it wasn’t a job for one person. On a subsequent visit alone, though, her therapist floored her with the pronouncement: It seems you’ve been suffering episodic depression. But no! she thought. Depressed is like my sister, who was suicidal. Depressed is like my friend who won’t get out of bed. I’m not depressed—ask any one of my friends—they’ll all say I’m the most positive person they know! I don’t want to kill myself—I’m not even sad—I just get frustrated with my husband and daughter. Or angry. —Nonetheless, replied the therapist, you might consider, with your family history of mental illness, taking antidepressants. Your aunt’s schizophrenic; she takes medicine. Your sister’s chronically depressed; she takes medicine, too. You might see what medicine could do for you.

Kylie thought about it, did a little research of her own on the Internet. She looked up the pages of information from the antidepressant companies and was surprised at the things they informed her were indicative of a real disease, things described as symptoms but which she had thought of as part of daily life: overeating, feeling tired, feeling less enjoyment of things. She had thought, before, that these were the hallmarks of life, of being a new mom, of grief over the loss of loved ones and of her job, of being up at night with a sick kid. Of course she was tired. And being at home all day was boring; of course she overate, it was something to do. And she didn’t much want to spend time any more with her old friends from the office, for after the initial enjoyment of being with adults again she’d inevitably feel left out as the chatter turned to office gossip and tales of the world she had left behind. But the shock of seeing her personal life represented as a list of symptoms that could be treated brought her around. Of course it wasn’t right to be this way. She was sick, and she should treat her disease with these pills that seemed tailor-made for the job.

She did, and her whole quality of life turned around.

2. Three Generations

The first Christmas without her Grandma, and the whole famdamily was up at Kylie’s mom and dad’s to make a go of it. Her dad moping and finding fault, saying, That’s not the way Mama would have done it. Offending her mom into bustling silence, and insulting Kylie, too. That’s how you raise your daughter? He’d ask her. Seems wild to me. You should keep her quiet. Then retreating to fuss with the new TV, muttering and occasionally swearing out loud in a barking voice. Her husband had already fled to another room.

Her mother took Kylie aside, whispered she was glad—glad to hear the news that Kylie was getting herself some good treatment for depression. Mom was a nurse, and she knew before Kylie did that she had some sort of medical condition. Knew Kylie should get some professional, medical help—after all, she herself was in the medical profession, saw how easy it was for people to get turned around by their chemistry until some good medicines set them straight again. Knew from her own activities in NAMI how important it was for family members to be supportive of their loved ones through their mental illness, to encourage their acceptance of mental illness as a circumstance of biology, not anyone’s fault, and to take without shame the relief provided by the wonders of modern medicine. Wasn’t her aunt a victim of schizophrenia?
Wasn’t Kylie’s sister depressed, too? Under her breath her mom advised Kylie not to fret over her illness; it wasn’t her fault.

The elder parents eyed the younger generations over dinner. Her mom looked away with a stiff expression and her dad scowled as the baby whined, said she didn’t like peas, and dumped them on the table. Kylie felt a flicker of anger, but where before she would have ignited and raged, this time she merely scraped the spilled peas from the lace tablecloth into her cupped hand. She felt the impact of her parents’ censure as though it bounced off a transparent rubber sphere all around her; she could vaguely sense the indistinct pings of those damning thoughts, but she couldn’t hear them clearly enough to be bothered. Not like she used to, when the thought of what her parents would do or think drove her to distraction, fueled her anger at her daughter and her frustration with her husband.

Her husband retreated again after dinner, and in the kitchen over soapy dishes her mother orchestrated another sotto voce attack. Her mom wondered aloud, as if to herself, if Kylie’s husband was good enough: Recall that time after Kylie’s jaw surgery when he couldn’t be trusted to take care of their infant daughter and Kylie was afraid to leave the child with him and afraid of returning to him to convalesce? Remember how he’d take the child straight from a swim class, neglect to change her wet diaper, and bring her home damp-haired in the middle of winter? Remember how, after Kylie had that ankle operation, he’d told her that since she’d elected to have the damn surgery, she could get up and get her own damn glass of water? Remember? Kylie felt the words ping more insistently against her rubber shell, but still felt a measure of numbness to their import. She felt her bubble encapsulated her in a time warp that gave her the necessary moments to collect her thoughts, decide what she needed to do to respond to this attack, what she wanted to say. She thought of her husband, upset but willing to accompany her to therapy, now biting his tongue in another room rather than striking back at her parents’ jabs. So she shrugged, said nothing, dried and stacked the dishes.

She bided her time, and before leaving addressed both parents at once. —We’re in couple’s therapy and are working things out, she said. Watching the knowing look that passed between them, she cut the thread of her parents’ thought. —I need you to stay out of it. It isn’t your business. However, the relationship between the four of us is your business, and if you’d like it to continue we all need to have some counseling together. We won’t see you again otherwise.

Leaving her parents dumbstruck on the curb, Kylie climbed into the car beside her husband and daughter for the ride downstate, home.

3. Relapse.

After a year, she still felt pretty good. Not like the first few days on the drug, when it was like she had rediscovered spring: a feeling of sun, and hearing birds—at the end of one of those early days, she had thought, That was actually a nice day. Looking down at her daughter, she wondered in puzzlement, What did the kid do differently? Realized, after all, the child was still two, with all attendant terribleness intact; the difference was in her. In Kylie.

Time passed and the first bright glow of rekindled spring settled into a more neutral palette. She still had feelings, of course, but she learned the bubble the medicine placed her in made her less reactive. She felt her tolerance for the things that had used to bother her had increased, enough so that when things happened she had enough time to step back and respond in a way other than frustration or pique. It felt good to be on an even keel. The eczema finally
cleared up, too, and she had found some books to cope with the ignominy of being a stay-at-home mommy. It wasn’t something to be ashamed of, wanting to be the one to raise your own child, and beside she had found a business venture, marketing do-it-yourself greeting cards, that she could do in her spare time at home. Not Wall Street stuff, surely, but it assuaged the desire to feel like she was part of something, and it tickled her that she had finally found something artsy-craftsy she was good at. Take that, Martha Stewart.

So after a year, she decided to wean herself off her meds. With her doctor’s blessing, of course. Things were going so well. Three weeks went by, and she took her daughter, then three, to a little cousin’s birthday party. Where the children acted, as they do, like three-year-olds, her daughter included. Her dad, cutting squares of ice-cream cake, shot Kylie a dark look from under his party hat and muttered something. Couldn’t she control her daughter better? What kind of mother would let her child carry on like that? Her anger, that had so long been dormant, flared up again. She snatched the child from a noisy game of ring-around-the-rosy, left the party abruptly with the child under her arm and tears streaming from her eyes. She drove around and around the neighborhood, crying. —What’s wrong, Mommy? the child asked, her eyes round and bright as pool balls. —I don’t know, sweetie, she said. But she wondered, and thought, This isn’t right. I shouldn’t be this way.

Two days later came the breaking point. Her daughter was in that stage that children all seem to go through, when she wouldn’t leave her shoes on. Would just take them off, again and again, all the time, either from discomfort having them on or for the sheer pleasure in the newfound ability to shed them. The two of them were driving somewhere, they were already late, and when she looked over the child had her shoes off again. No joke, she had already put those shoes back on ten times that morning. So when she caught sight of those little stocking feet kicking breezily in the air, she lost it. Yelled, Why can’t you leave those damn things on?!? The feet stilled and the girl turned to her, said in a tiny voice, Mommy, don’t call me “damn.” And that’s when she knew, for sure. This was not how things were supposed to be. This was not the mommy she wanted to be. She had to go back on the drugs.

Postscript: Irreproachable Daughter, Peerless Mom

I left my conversations with Kylie struck by the contrast of the sad self she described with the chummy, easy-to-talk-with woman she appeared to be in person. I’d mentioned this to her, and she confided that this was why she’d had trouble believing herself depressed in the first place: Can a cheery person who is sometimes angry be depressed? But seeing her problems defined as symptoms had convinced her that she was depressed, and after she had accepted that and had accepted antidepressant treatment, she found that the cheery woman she was in the professional and public spheres made more appearances at home, too.

When Kylie embraced her diagnosis, she embraced the medical cure as well, though the thread of a medicalized understanding of her experiences made for a minor warp in the weaving of her story. With her mother’s employment in the medical profession and involvement in the National Alliance for the Mentally Ill (NAMI, an advocacy organization for “consumers, families, and friends of people with severe mental illness;” “About NAMI,” 2005), it was unsurprising that Kylie would be familiar with and accepting of a conceptualization of her personal problems as a medical disease. She took the antidepressants because “[she] knew it was what [she] had to do;” but what was it Kylie felt she “had” to do?
Kylie didn’t define her problems as an issue with her brain chemistry. As she saw them, her problems stemmed from her resentment of her child—the child for whom Kylie had given up her job to raise, a choice she was not forced to make but wanted to make and wanted to feel good about—and her difficulty obtaining emotional support from her husband and parents. Kylie had tried and rejected the role of the working mother, feeling that, though she would miss the confidence and respect her job earned her, she ought to be the one to raise her own child. And Kylie felt grateful that she could afford to make that decision, but that gratitude was complicated by the guilt she then suffered when she did not enjoy raising her child: when she was bored, or angry, or tired, or frustrated. She’d gotten what she wanted; why wasn’t she happy?

Kylie saw a twofold answer to that question. First, she lacked emotional support from her husband during what she identified as difficult periods in her life: her bouts with chronic and passing illnesses, her grief over losing her grandmother, and her trouble adjusting to the role of full-time mother and housewife. Second, she lacked similar emotional support from her parents, and when she managed to escape from their direct censure she still experienced it in her mind as memories and worries about how her actions would look in her parents’ eyes (“I hear their voices in my head, or I wonder, ‘what would they say? What would they do?’”). To conquer these problems, Kylie would need to become a mother and daughter beyond reproach.

I could begin to understand how Kylie’s conception of her problems had led her to accept the diagnosis of depression and its attendant course of recovery. She recognized that her marital problems were not hers alone, and she took steps to include her husband in the repair of their relationship. But Kylie saw anger, frustration, and worry as her own personal failings, ones that would have to be ameliorated before she could begin to work on the relationships with those (parents, child, and husband) who had kindled those emotional reactions in her. And that tamping-down of troublesome emotions, she learned, would be achieved through medication.

“The antidepressants bought me time—I wouldn’t react angrily right away to things that had bothered me before,” Kylie mentioned. Her responses would be numbed, and the relief from painful goading could allow Kylie to step back from a upsetting situation—say, a disagreement with her mother—and decide what she wanted to say, how she should act. This numbing bubble helped her become the daughter she wanted to be and, especially, the mother she wanted to be. “You shouldn’t freak out just because your child is acting like a two-year-old,” Kylie admonished. This conviction was strengthened when Kylie dared to go off her medication and found she quickly plummeted to become again the bad mom who yelled at her daughter and the bad daughter who could neither please her dad nor endure his criticism.

Was Kylie disempowered by her use of medication? Having learned something from my previous conversations with Lila, I tried to shed some of my preconceived notions about what it meant for a professional woman to become a mother and housewife. But even if I hadn’t, Kylie would have listed the hallmarks of the problem as she described her conflict with the transition: losing financial independence, losing the respect engendered in a professional environment, and losing a sense of being useful in the larger world, all in the cause of taking on another job which, no matter how important, exhausting, or time-consuming, did not garner the respect and benefits of paid employment. The use of antidepressants didn’t figure one way or another into Kylie’s notion of how to cope with that disgrace; for her, it took time, self-help books, and finding other avenues for her entrepreneurial spirit and business sense. The recovery she engineered was suited to her and successful; Kylie was proud of her triumph in this and has considered herself as an advocate for other new mothers in similar situation.
Antidepressants had a greater role to play in making un-problematic the difficult relationships in Kylie’s life. The numbing effects of the drug protected Kylie from some of the pain she was used to experiencing in interactions with her family, especially her parents, allowing her to respond differently to those provocations in the interest of learning to have a different kind of relationship. This seemed only somewhat successful in interactions with her parents—Kylie reported that their hurtful patterns of relating to her remained unchanged; though, once she was back on the antidepressants, she could ignore them better—but was seen as an unqualified victory in Kylie’s relationship with her daughter. “It’s so important for me to be the kind of mommy I know I need to be,” she confessed. “I shouldn’t get mad, or frustrated, or yell—my daughter’s just a little girl; she doesn’t deserve that.”

Kylie, like her mother, saw herself as an advocate for consumers of antidepressants. “I’m not ashamed to tell my friends and my co-workers how much medication helped me,” she said, “and I urge them to get whatever kind of help they need to feel as well as they should.” A kind of fervor of conviction came into her voice as she continued: “We’d wanted more children, but it was so hard in the beginning with my daughter, and difficult emotionally during the pregnancy, too, that I didn’t think we could do it. But now we’re thinking of trying again. I really feel like I can do it right this time—that, if I take the antidepressants, I can be the kind of mommy I need to be.”

After Kylie left, I remembered the Zoloft blob mom, medicating herself because “you get only one chance to bring up your children.” I didn’t know if Kylie had seen this line of advertising or not, if she was leading or riding that particular bandwagon. It didn’t matter; I suspected the selling of saintliness as the goal of motherhood has been a marketing message for a wide variety of consumable products, for a long time. Good moms sweeten lunches with little cups of pudding, soften towels with fabric softener, and sweeten and soften themselves with drugs—antidepressants, anxiolytics, antihistamines, anti-inflammatories—anything to soothe symptoms that might otherwise interfere with successful mothering. Weeks after we met, reports came out in the media about the dangers of birth defects in children born to mothers who consumed antidepressants during pregnancy (Carey, 2005; FDA, 2005). I tried to imagine what kind of bind that would place Kylie and other mothers like her in: How would she decide to do right by her baby?

I wondered if it was churlish of me to be suspicious of Kylie’s desire to treat her daughter with more kindness and patience than she apparently received form her own parents. Did she think her failure to do so was due to a medical condition? I had asked her this, and pointed out that, according to her own account, she had no difficulty dealing with frustrating and unsupportive people outside of her family, and that the symptoms or troubles she described were directly tied to discrete situations. Kylie considered my question: “I had never really thought of that before I came here to talk with you,” she answered. “I think you’re probably right, but I guess for me, now, it doesn’t matter. What matters to me is doing the right thing to be the way I want to be, and this is it.”

Kylie’s words stayed with me over the next few weeks when I met and spoke with Jenny, a 48-year-old woman who had grown up and lived still in the rural area just outside of town. She contacted me after her husband came across my flyer in Wal-Mart and brought it home to her. After a short series of businesslike emails we arranged to meet, and I found her in person to be much like who she was in her correspondence: direct, a little terse, outwardly wanting to be communicative and helpful but a little guarded as well. She spoke in short, clipped phrases, but I admired the way she maintained steady eye contact with me, even while her hands were clutched.
tensely in her lap. She reminded me of a wild little bird eyeing a handful of proffered seeds, keeping her distance but cocking her head and wondering if it would be safe to move in.

I wished I could have put Jenny more at ease, so in retrospect I imagined her telling her story in a manner that might have felt more comfortable for her. I pictured her in her kitchen, at home, enclosing her thoughts in a diary that she might share with me. It would have been a no-nonsense diary, with plain white pages. She would write in her clear, old-fashioned script, and her handwriting would allow her to make graphic emphases that would seem too embarrassing if spoken aloud. I could imagine her closing up the diary, wrapping it in a paper bag, and delivering it to me with a businesslike handshake and few words.

**A Week in the Life**

April 27, 2005

Well. This is Jenny.

I tried to sit down and think about how I wanted to describe this to you. I think that the most important thing is to describe my agenda (that’s what I call it) because I feel like it kind of rules my life and figures so much in how I got depressed. My agenda is just my mental list of things I have to do. Some of it is the little things everyone has to do: cleaning the house, doing laundry, getting meals on the table…just little things. Raising kids. Some of it is what I call my “obsessive stuff”: things at home need to be in a certain order. I need to get the groceries once a week, I need to check my email at least every other day. It’s stupid stuff, but if I don’t do it I feel real out of control. If the mail starts piling up and I haven’t gone through it, it starts bothering me. It really starts bothering me. It looks so trivial when I’m writing about it, but it really bothers me. For example, I’m a home healthcare nurse. I’ve been a nurse of some kind or another for over 20 years now, but I’ve only been at this particular job for a little more than a year. And I like my job real well. It can be a little erratic, at times, but I like what I do. But when things that are projected to take me six hours take eight, and start to interfere with everything else I have to do, I don’t like that. I don’t cope real well with that. I’m not very flexible. Being flexible makes me feel too out of control.

For example, about ten years ago was when I started feeling really depressed. I have some problems with anxiety sometimes, if I have a lot I have to do, or if I have a lot of evenings scheduled for work and other things going on…I get real overwhelmed and frustrated and **angry**…angry at myself for not being able to do it better, I guess, or handle it better. And, I guess, angry at my husband for not picking up the slack. Back then I was (well, I still am) really, really a fanatic about my house. I was also working, and my kids were involved in a lot of things, so I was really busy. I was working four days a week, and I was so upset with myself that I couldn't get everything done with that extra day off a week. It seemed like I should have been able to manage it, but I couldn’t. I couldn’t stay on top of the house cleaning, or the laundry…it still seemed like everything piled up. And we were spending evenings with the kids’ activities, so I couldn’t catch up then. And that was really a problem with all the kids still in the house, because obviously kids and a clean house don’t go together. And they would mess things up, and I’d clean things up, and they’d mess things up, and…I’d be so **ANGRY**! At night I would get overwhelmed with just thinking what my week would be like. “How am I going to handle all this, where’s the time going to come from? I’m going to be tired, I’m going to be grumpy…” That anxiety would just build up until I was overwhelmed, and I was waking up in the night and not being able to go back to sleep, just thinking about things, and worrying, and crying.
My time is up for this now, and I have to get some other things done. I’ll continue with this later.

April 28, 2005
I’m back.

About depression…I was diagnosed a little over ten years ago, though I probably had it for a long long time before that. It wasn’t to the point where I was non-functional…I just finally realized I was tearful all the time, I was angry…a lot of it seemed to be linked to my hormones. Then things started coming out more in publications, and about PMS, and there was more publicity about it on the news and in advertisements and such. So what happened was I finally went to an Employee Assistance Program counselor at work, and she did the depression scale and I came up with “Severe Depression.” I didn’t think it would be severe. I was surprised. It was upsetting to think “why me, why do I have this…why can’t I control this? I’m just a weak person.” I know intellectually that’s not right. But when it’s you, you think you should just snap out of it. No one told me that (my family is very supportive) but I told myself that. Why couldn’t I just snap out of it?

The EAP counselor suggested I try some antidepressants. I went to my family doctor at first, and he put me on Prozac, which I’m still on. But I had some problems with side effects…mostly sexual side effects. My body just wouldn’t respond. So I was frustrated about that, so I saw a psychiatrist who adjusted my dosage and that got better. I’ve stayed on it since then except for one time when I did go off of it, about two years ago, maybe. I tapered off with the guidance of my doctor and all. I didn’t admit it, but my husband said “you’re just not right”…I was sad all the time, and anxious, and overwhelmed. I get overwhelmed very easily, even now, but then it was just with all of life’s tasks, and things I had to be responsible for. So he said I probably needed to be back on medicine, and I went back to my doctor.

Counseling has been hit and miss for me. The EAP counselor…I never really felt like I connected with her. She seemed to have very simplified solutions, like: Get my husband to help out more. I saw another counselor here in town for a year a couple years ago for my history of childhood sexual abuse. I thought maybe that was some of my problem with depression and also with some issues I was having with my husband. That helped some. I think what really helped for me was I also had some sexual abuse counseling with my pastor, who counseled a lot of women in the area with the same problem. We all had a little support group and everything, but he left for another job and the group just sort of fizzled out. And sometimes I wonder about the abuse, how much did that relate to my depression? I’m sure at some level…but I really think there’s more of a hereditary level. My brother was manic/depressive, I had a depressed and alcoholic uncle, then there’s me, my daughter, and I think probably my sister was, as well. But sometimes I still think about it, and I can’t pretend that it never bothers me. I’ve made a lot of peace with it, but it never really goes away.

I’ll write more about that later.

April 29, 2005
I was sexually abused by my sister’s husband…it’s a vague memory. I was four when they were married. I don’t remember anything happening before that, but I remember things after that. I would say it went on about three or four years. The only reason it stopped was because my mom and I had a discussion one day, out of the blue kind of, something about how you should never let anyone touch you, and stuff like that. I was really scared then, because he had told me
“you’re really going to get into trouble if you ever tell,” but that day I was talking to my mom I finally cried and said “I don’t want to get into trouble...” and I told her. I think she handled it pretty well, considering it was her other daughter’s husband. All I know is, later she told me she talked to dad, and I don’t know what dad threatened him with, but he…it never happened again.

I confronted him a few years ago when I was going through all that counseling. I had written him a letter, and about a month later he wrote me back saying he didn’t remember doing anything. But he was almost a little remorseful, like “if I did do anything, I’m sorry,” but then he also kind of blamed me a bit. He used to make offhand sexual remarks to me, when I was older, a teenager, and when I confronted him about that in my letter he wrote back that I “shouldn’t have worn such short skirts.” He was like my first husband…he liked women. Too much. He ran around on my sister, and I wasn’t the only kid he did that to. I know for sure about at least one other, and my niece has a recollection of him kind of rubbing up her leg.

He died about a year and a half ago. I went through some really weird emotional stuff then. I’d wanted things resolved, and now he would never say he was sorry. And there was also the loss of this kind of helpful big brother, which he was at times, and who I really loved, sort of, when I could put that other stuff out of my mind.

When I look back and think about it, part of me realizes I was only four, and that as an adult I would never blame a four-year-old for her own abuse. But part of me thinks I should never have climbed up in bed with him when he said “C’mon, let’s snuggle.” I should at least have told him no. I should have told my mom that first time. It complicated my relationship with him, sure, but I think it complicated my relationships with the rest of my family, as well.

But that’s another story. For tomorrow. The laundry is waiting....

April 30, 2005

I used to have a lot of family in the area, but by now so many of them are gone or alienated and that’s been real hard. I’ve always kind of had a hard time having people to be close to. When I was young I was fat, and the other kids at school used to tease me. I keep thinking I should be over it, but it still hurts. So I had imaginary friends in grade school, and I had one good real friend who didn’t mind playing with the fat girl. She moved out of state about the time my dad died…I remember standing by the kitchen door, crying, when I heard she was moving away. I was about 12 then. My mom was older when she had me, and was in her 50s by then, and she was going through her own problems with raising me alone and going through menopause and such. She really kept me in line about things like boys, and my chores, and going to church. I didn’t mind…I was sort of a loner, anyway, and I just focused a lot on my studies, and I guess my perfectionism started coming out then. I was a good student.

My first husband was my high school sweetheart. We’d been dating since 10th grade, and we married after we graduated. He’d always been real sweet but after we graduated he started to go wild. He got involved in drugs, and he started fooling around with other women. He left and came back a bunch of times, and one time when we were sort of reconciling we stupidly decided to have a baby. But he must have gotten his girlfriend pregnant at about the same time as me. He confessed later…he said, “there’s something I have to get off my chest,” and told me that he had arranged and paid for an abortion for this other woman. He told me this when I was about nine months pregnant. I couldn’t take it, I had to just leave to go cry at my friend’s. A few weeks later I had my first child, my daughter. I got really straight after I had my daughter…I didn’t want to bring her up in a place where people were coming to the door to buy drugs. I left my first
husband pretty soon after that, and I met his best friend and married him, which was sort of ironic. But he’s a good man, we’ve been together now over 20 years.

My immediate family has mostly slipped away. My brother (who was 12 years older than me) was an alcoholic, and manic-depressive, and he never took his medications. He would come home and terrorize me and my mom when I was young, and I don’t know why she never called the police on him. She’d just give him money and hope he’d go away. He died at 43. In some ways, my sister’s husband was more of a big brother to me, despite that stuff that happened as a kid. He’d help out with car stuff, and look out for me when I was older. But he made me so mad, too….he had affairs on my sister. The worst one was when she had breast cancer and really needed him, and he moved out to live with another woman. I called him about it and he tried to tell me that he and my sister were really separated, and that the only reason they weren’t divorced was so she could stay on his health insurance while she died. She died at 48 from that cancer. I think my sister’s death was the hardest of all, even more than my mom’s. It was so unfair…my brother had abused his health, so his death made some sort of sense, though it was tragic. But so many bad things had already happened to my sister, and none of them were her fault. And even though I criticized her husband for not being there, I wasn’t there with her as much as I should have been, either. I wish I had taken better care of my sister. I have some regrets about that now. But, back then I was so focused on my agenda.

The last few years of my mom’s life she had Alzheimer’s and we (my kids and I) tried to spend time with her… I wanted to be more involved than I was with my sister. We’d go up to visit, and she was such a sweet and charming old lady, but she didn’t remember any of us…how do you spend time with somebody who doesn’t know who you are? She died about eight years after my sister passed away, but by that time I was on antidepressants, so it was easier.

I tried to keep up relationships with the rest of my family, but I really got alienated from my nieces and nephews a few years back when I confronted my sister’s husband about the sexual abuse. They thought I shouldn’t have told them, that I should have just kept my mouth shut. One time I tried to have everybody over at my house for Christmas. Two nieces showed up for a little bit, but nobody else came, or called to say they weren’t coming. We just sat there, with all that food, and tried to act cheerful. It was the hardest time, to see my family slip away. My husband…he tried so hard to be nice, but he just didn’t really get it. He said, “well you still have my family, can’t they be your family too?” He meant it well, so I didn’t have the heart to cry in front of him when he said that.

At least now I do have my husband and my children. My husband and I are in couple’s counseling now, too. We’ve been doing that for over a year, and I feel like we’re making great strides. It’s not like we were on the verge of divorce, but things weren’t clicking like they should have and he was angry because I was always so preoccupied with my agenda. I’m kind of obsessive, like I mentioned. It’s my coping mechanism for when I’m feeling overwhelmed or depressed.

My husband’s pretty good, actually, compared to most men, but it never occurs to him that the dishes are piled up, or that laundry needs to be done, or…and I come home to that, and it’s still my job. Basically. And he’s been sitting there watching TV all evening. I come home late, and he’s already eaten but hasn’t thought to fix anything for me. I’m so regimented, that I want to be able to be home in time to make supper, clean up and all. And if I’m not going to be home in time to do that, I call him up and kind of give him orders. But sometimes he’s already eaten, and he has other things he wants to do, and I guess I have to respect that. He’s not my slave. My ideal husband wouldn’t sit down to rest until I sat down to rest...but he just thinks I’m
crazy for having such high standards. And when I ask him to do things, he thinks I’m passing out orders every time I talk to him. Which is true. If I have to choose between order and relationship, I choose order every time. And sometimes it takes away from the relationship to get him to do whatever it is on my agenda. But, we’re working on it and I think things are getting better.

May 1, 2005

It is better, but I still have those elements there…I just think I’m not as driven. This is managed depression…where things aren’t sad so much, but I still feel kind of yucky. The anxiety is getting worse, though.

The antidepressant did help with the obsessive-compulsive nature that I have. I can let things go, where before it would make me sick if I did. Now, if I come home, I’m too tired, it’s late, and there’s still a pile of dishes, I’ll let it go. Even though it bugs me and I hate it, if I’m tired I just let it go. Now my daughter and granddaughter live with us, and the house is trashed 99% of the time. Most of the time I just let it be that way, so I’m better. I just let it be that way. So I’m better. I feel like it’s just going to be that way again if I pick it up, so why waste the effort? I put more of my effort into things I can control better, like junk mail, which is my job.

Now, if I do get interruptions in my agenda, I can cope with it a little bit better. I still have an agenda, but if I get interrupted I don’t feel so bad about myself now. Like before, I would have thought “well, I was supposed to get items 1 through 10 done today, and I didn’t, so I’m a bad person.” But a couple weeks ago my daughter’s fiancé came over on my day off ’cause he needed to talk, they were having some issues they needed to work out, and I guess he felt comfortable talking to me…so, he was there for quite a while, and I basically had to drop everything I was doing and talk. And there was some things I needed to get done…but I was able to take it in stride. I was maybe a little frustrated that I didn’t get things done, but I was able to look at it like “well, you were able to talk to him for a couple hours, and that was important.” So I think I was able to see it from a more realistic point of view.

It was the right thing to do, it was the right thing to drop that other stuff and talk. And I was OK with that, whereas ten years ago I probably would have freaked out. Not at him: I would have still been very pleasant and helped him out, but in the back of my mind I would have been stewing. And later I would have been slamming down stuff. But now I can just sort of let it be, get things done when I can and just sort of deal with it, sort of, when I can’t.

Postscript: The Poison Is the Cure

Jenny and I made our goodbyes and I watched her go, her birdlike shoulders braced against the day. I couldn’t help comparing her to Kylie: Both women stated they were “just doing what they had to do,” but Kylie seemed buoyed by this decision, whereas Jenny seemed burdened—though she saw herself as “better,” or mostly recovered, from her depression. Was the difference between the two women in the quality of the recovery, or in the nature of their depression?

Both women’s stories fit, to a certain extent, different feminist conceptions of disempowerment and depression. Kylie suffered the ingloriousness of leaving the professional world for the role of homemaker, though she didn’t put the shame of this at the center of her own conception of depression. On the other hand, at first blush much of Jenny’s story appeared to grow around a different feminist dilemma, the “second shift” (Hochschild & Machung, 1989) problem wherein women working full-time also put in a full day’s work after hours in childcare.
and housework. Jenny talked about how much this exhausted her, and stressed her, and how she would lie awake at night crying and wondering how it could all be done. But who put this burden on her? Not her husband, who would rather Jenny not run such a tight ship. It didn’t seem, either, that Jenny felt pressure from her upbringing or her social circle to be the perfect housewife. Jenny held the whip over her own back, making her standards, her need for order, and her “obsessive qualities” into what she came to frame as her agenda. And her agenda was both her bane and her salvation.

At first, Jenny framed her agenda as the cause of her depression. She couldn’t keep up with it, it haunted her, and she felt like a “bad person” when she couldn’t keep up with it. Its dimensions swelled in her mind until she couldn’t think about anything else, couldn’t worry about anything else, and she was consumed by it. She wished her husband would help out more, or, really, that he would be the perfect mate “who wouldn’t rest until she did.” While she was fantasizing, she wished she could keep her home in perfect order despite its housing of three normal, messy children. Jenny knew that these were pipe dreams, that she couldn’t make her family conform to her standards. But she thought perhaps she could control her own life in such a way that she could achieve her agenda, and she broke against this struggle.

Jenny began to define her recovery as a state of not-caring, as assisted by medication, about the state of her agenda. She still had her agenda, but if it wasn’t satisfied she could at last let it go and not feel too bad about herself for doing so. Jenny was relieved by this, for she recognized that the tyranny of her agenda threatened her relationship with her family: She became angered at them for disrupting it, and they became angry at her for being in thrall to it. Why, then, did Jenny still maintain her agenda? Why didn’t she see recovery as the abolishment of her agenda, rather than her construction of an uneasy truce?

“My agenda is sort of my coping mechanism for when I’m depressed or anxious,” Jenny explained. It would appear that Jenny saw her agenda as not the only source of her depression, that sometimes it was her version of a cure. But the rest of what has possibly shaped Jenny’s depression didn’t figure largely in her story. She wondered if part of it was her childhood experiences of abuse, but….She wondered if part of it was the dissolution of her family, but….She wondered if it was largely hereditary, but….What ultimately made sense for Jenny was what made her feel better: If antidepressants made her feel better about her agenda, then her agenda was the problem that needed curing. But it also seemed from the course of her narrative that antidepressants weren’t the cure in themselves, but were what helped her to go back to and cope with her agenda. And the agenda itself was a both curse that needed to be allayed and a cure that had to be recovered, that must be maintained.

Did the antidepressants keep Jenny from discovering what depression her agenda protected her from? From wondering about the meaning of control in her life, and how control could be applied to chores, versus people, versus the past? Perhaps, with her medical background, she was content to leave the source and depth of her dismay unexamined, if medication could bring her to a point where she was comfortable nursing the delicate condition of her relationship with her agenda. I imagined that relationship keeping her in a difficult position, with her head above water, but swimming at the surface of an unimaginable void. Then I tried to imagine that position from her perspective: precarious, but it kept her eyes dry, and she could see the shore she’s swimming for.

I shook off my ill-defined regrets about Jenny in preparation to meet Avery, a 20-year-old student at the university. I had originally wanted to avoid interviewing students, and put up my flyers in locations removed from the school and its immediate environs in an attempt to
contact who I thought of as “adult” participants. I should have known better than to be so dismissive, as the very first moments of meeting with Avery showed me. She looked an interesting mix with magenta streaks in her shaggy dark hair and a hint of a belly button ring underneath her proper interview blouse. She was small, trim, and fit, with a gamine smile that flashed at me from time to time. I was charmed, and listened with enjoyment and rapt attention as she spun out her story for me over a couple meetings. I admired her candor and felt lucky that we had achieved such a fruitful rapport…so it was a great surprise to me when our collaboration ended the way it did.

What Doesn’t Kill Me

August, 2005

It’s been months since I’ve last seen Avery.

We parted on good terms, I thought, with the promise that we’d meet one last time to finish talking about her story, answer and ask questions, and compare ideas. Avery wanted to wait until the semester and the pressures of schoolwork ended, and I agreed. She’d mentioned wanting to wean herself off her medication by then, and I’d be curious to see if she’d made the kind of progress she proposed for herself, if she’d have regained the attention and composure to reclaim what she thought of as normal functioning.

But when the semester ended Avery became difficult to track down. She didn’t answer her email, or her phone at home, or her cell phone. I’d become a little concerned as she had seemed so enthusiastic about the project before, sharing her experiences with a frankness I found touching. One of the things she’d mentioned with pride was her sense of responsibility, and it didn’t seem like her to blow off an engagement without word or excuse of any kind.

In mid-summer, Avery called, and left a message: something about having been hospitalized for four days at the end of the semester for “some sort of problem with medication,” and how she was now living at home. I could reach her there; she left her new number, and said she’d be checking her email.

I called, we corresponded, and we set up a new time to meet. In the meantime, I told her, I’d send her my thoughts about our talks so far, with additional questions I had for her and an initial analysis of her story so far for her commentary or corrections. I fired off my documents and waited eagerly for a reply that never came.

First one appointment was cancelled, then another proposed and rescinded almost within the same day. We finally settled on a meeting today, and I thought she’d sounded friendly as ever when we made our plans. But there I sat; I’d been waiting an hour.

While I waited, I attempted to reconstruct our first conversation, recalling her words and guessing what she had been thinking to herself then, using her revelations from later conversations to construct a version of what might have been going through her mind when we first met.…

February, 2005

Ya know, about a year and a half ago is when it happened. I was starting my second year of college, and about five days into the school year I became apathetic and didn’t want to socialize or anything like that. And that’s just really not my nature at all…I am an outgoing person. I just would sleep all the time, or there were weeks when I wouldn’t sleep at all…I didn’t have any control over when I would sleep or be able to stay awake, so I stopped going to classes.
Ya know, normally I’m like a 3.7, 4.0 student, so when my grades started slipping it was like—I sort of lost who I was, if you know what I mean. But it was about six months or so before I got any sort of treatment.

But I think I finally got to a point where, like, a light bulb came on. I was in the shower and I was just, like, “what the hell?” Ya know? Like, “it’s two o’clock in the afternoon and I am just now getting up, I haven’t gone to any of my classes today. I am so behind,” ya know?

I couldn’t even describe myself anymore. Or, like, every part of me that I had had was gone. I didn’t know who I was. I decided I needed something to help get me out of that, and since I didn’t feel ready for counseling I wanted to get some drugs.

My mom, ya know. She’s actually a counselor, which is ironic ’cause she’s the last person I would go to, to talk about anything. She’s really intense, ya know? We just don’t get along at all. She’s pretty anti-medication, and she’d be, like, “you don’t need to be on drugs.” I did eventually go for counseling, but I sure didn’t want to talk about it with my mom first….

(As if I would talk to mom…I spent enough years trying to be the “good kid” for her. I played that goddamn tuba for eleven years after my brother got sick of it, just so she would have that dopey look of joy on her face. I was Ms. Perfect in high school, but she just couldn’t stop being doubting and controlling. No wonder it took me five years to tell her about…it. No wonder it took me months to decide to get the help I needed for depression and months more to tell her about that, too….How long have I been spacing out thinking about this? Siri looks confused.)

So anyway, I didn’t want to tell my mom about that. I went by myself to my family doctor and was, like, “this is what’s going on, I’m depressed, I can’t do anything, I don’t feel good,” and he put me on Lexapro. I tried that for a couple of months, but it didn’t seem to do anything. I think any difference I felt was like a placebo effect, ya know? So I switched to Celexa, which I was on for a long time, but I think I built up a tolerance to it so now I’m on Wellbutrin. And I have ADD as well—ya know, I couldn’t concentrate in any of my classes—so I’m on Strattera for that.

See, at the beginning of school last year, it was like all of a sudden I started dropping balls. And I’m not like that. I’ve always had 3 balls, 8 balls, 22 balls in the air. Like, my normal day in high school would be to get up at 4 AM, feed my 4-H animals, drive around town picking up kids for swim practice—I was the swim team captain—make sure they got breakfast, go swim for a couple of hours, and then go to school. After school I’d do it in reverse: more swim practice, or cross-country practice if that was the season, drive the other kids home or wait around with them to make sure they got picked up, get home by 6 or 7, feed the animals, and do homework. And then maybe have time to do something fun. And after…I mean, after a while, I was sick of high school—I hated being there. So I found a loophole in the system that would let me do volunteer work and independent research and it let me graduate early….

(I had to get away. I got away and I had to keep getting away. For six years now I haven’t lived in the same place for more than a year. It’s hard not to have good friends, but it helps me to disconnect easier.)

Anyway, I have a big fear of not being successful, but I want to be successful without anyone else’s help, ya know? I want to be able to take care of those 35 balls by myself. But I think last year, well, I finally took on so much that I just couldn’t pay attention…well, I couldn’t get through a lecture without thinking about other stuff and other problems or things to fix…well, this needs explaining.

Back in high school, I was such a super-achiever I didn’t really have any close friends. Getting good grades wasn’t hard, and my own stuff didn’t take up too much time, but I was also
busy taking care of everybody else. I was always there for my friends and they’d always come to me with their problems—but I didn’t ever really open up to them. It was more like I was their mom than their friend. But, really, I was much more mature than all of the people around me. So I didn’t really need—I kind of kissed off everybody in high school and was, like, “whatever.” I didn’t need them to take care of me.

I guess part of that explains why I have a thing for older men, then, ’cause I can’t stand guys my age. I mean, I’ve had my experiences but….But last year that got sort of out of hand, because I got involved with the wrong guy, and he had all these problems, and so for two years it was just like: I’d wake up and I’d think about his problems, and I’d go to bed and I would think about his problems, that was all I could think about. Like, he was married and his wife actually, uh, ya know he’d come see me with black eyes and stuff. Recently she just shot him with a .22, in the arm. It was sort of scary, because I was so obsessed with “how do I fix this, how do I fix that?” And um, I helped him financially as well, um, probably $6,000. You know, I’d work at my $7 an hour job, then I’d figure out exactly what I needed to function on. And then the rest of the paycheck would go to him for, like, his electric and um, his child’s school, and clothing, and food.

And then my quality of life just depleted.

I had a really hard time and it pissed me off so much because, like, this was all for a guy who was emotionally unavailable, physically unavailable—yet I was completely attracted to him. But he said things to me like “ya know, I’ve thought about being a family with you.” And I think he was really good at mind-fucking me, ya know? But he’s the first person I fell in love with….

(How do you explain a love for someone you trust even though they act so untrustworthy? I never had flashbacks with him…I thought that had to mean something, but maybe it didn’t. I thought it meant something that I could actually want to be with a guy, but I guess it didn’t.)

Well, we had an affair I guess. I mean we didn’t do anything, you know, physical together ’cause it just didn’t reflect well, so, that was kind of it. We were just good friends. And it’s funny ’cause like, we were really close, but like…we never talked about me. I never told my life to him. Like, I still haven’t figured out how he actually felt about me. And some days I’m like, “yeah, I let myself get used,” ya know?

(Flashbacks help me remember that I shouldn’t trust guys…that I have to keep my distance. Don’t get too close. I should have remembered that. Anyway….)

But that person I was when I was in love with him was just gross. It just grossed me out. Ya know? The person I became. Like needy and…needing someone to please for validation. And I hate that. I shouldn’t have needed him or anybody….

I think the way things ended up with the guy, it just like, I started to open up and I started to feel….uh….And then it all went bad, so I think I really shut down….

(Be one of the guys. Remember. Be one of the guys so you can get comfortable with them again. You can get close. But not too close.)

But now I’ll know never to get that close again. That’s the attitude I have. Like, I will never emotionally be as vulnerable as I was with him. And if I start to see myself—I will completely divorce myself from the relationship. ’Cause that sucked. I’d rather go through the experience of… I mean, um, go through anything, than relive what I went through with him.

So I began to try to distance myself from him because I could see that it wasn’t healthy for me. But then I was introduced to one of his friends who, um, is in the same situation, and I now see myself having the same patterns: ya know, taking care of him, and giving advice, and being supportive. And there are some other married guys I’m befriending in that way, too.
So, but with these guys, I’ll do all the physical stuff with them, too, and I’m there for them and I’m their friend and everything but…like, um, like as far as sex goes and the physical stuff…I don’t want anything from that. Do you know what I mean? Like, I don’t mind being there for them, but I’m just there for them. Like, I don’t feel anything. Like, I can almost feel myself coming out of myself and, like, hovering above the situation. Sort of, like, watching it all happen. I totally disconnect. Totally disconnect. That doesn’t mean I don’t like them, or I don’t want to be with them, I just don’t….

I just don’t want to feel anything.

But I think this time it’s better, because I don’t have any romantic feelings, ya know? Which is also why I think I go for married men, because part of me feels safe because I can’t get too close. ’Cause if that is what love is, like, well then, I don’t want to be in love ever again! Like, when you want to be with somebody so much, that wondering if you’re going to be with them or not makes you, like, physically sick? I stressed so much over what he was doing, my life was falling apart, so that I would all of a sudden vomit or get big migraines.

But I learned a lot from him, I guess. And from….They’re, I mean, it’s a good lesson. Make me smarter….

(The relationship and…the other experience I push far away, but I hold really close. Like, I don’t know. I don’t, I have no idea why, but I do find it really comforting. To get a flashback—I’m like, “ok yeah.” That did happen, and now I’m over it. I’m glad it happened to me and not one of my friends. ’Cause now I know I had the strength to deal with it. And I think it’s made me a very strong person. Yeah, I mean, I’ve never felt sorry for myself. Or felt like that shouldn’t have happened, or sort of cried because it happened or—I’m just like, “ok, well, that happened, and ya know, it’s part of life.”)

Now, I’ll be in situations and I’m like, “well at least it isn’t…I’ve been through worse.” I just sort of have this idea of, sort of, “suck it the fuck up”…just suck it up and persevere.

I guess…I guess what I didn’t mention was that when I was fifteen I was raped.

It happened, but now I’m over it. I mean, I didn’t even tell my mom about it until I was 20. And I haven’t spoken with my dad at all about it. But I know that he knows. So, we just don’t really talk about it. And I wouldn’t, like…if mom brought it up, I’d not, I’d leave the room. I would not even go there. I don’t want to talk about it.

But I don’t think that has an effect on what really upset me.

For me, depression is about more than not being happy. It’s…something that eats away at you. In high school…how the hell did I do all that? I should be doing more now. I expect more of myself, and I’m not fulfilling what I’m capable of, and that’s pissing me off. And that bad relationship really put me off that path, of being able to keep my momentum…I lost my identity when I stopped being able to do all those things. And then I’d get really depressed and not want to live anymore. I didn’t have anything to feel any self-worth over—I had nothing left, emotionally, physically—nothing left.

Getting better means being able to pick up the balls again. I think the more successful I get at doing other things, the more successful I am at getting over the guy. I can prove to myself that I can do stuff, that I don’t need people.

(If I can keep busy enough, I won’t be distracted about needing to be close.)

Part of me knows that I deserve more—part of me knows—but part of me still keeps relationships where I know I’m not getting a lot out of it, but I feel comfortable enough….

(Part of me enjoys having the nerve to stand up to guys, then, when they take me for granted. Say to them, “the minute you lose respect for me is the minute I fuck up your world.”)
And I love that moment when they recognize that I could tell their wives, that I had a trump card. I’m not the kind of person to blab, but if you don’t respect me... I could fuck up your world. And I guarantee it. And knowing that I have that power... it’s a good thing.)

The drugs help me get there, to where things don’t hurt so much and I can concentrate on picking up all the balls again, get them back into the air. The antidepressants just help me stay a little more positive. I just have more... I guess it helps me believe in myself a little bit more.... I don’t let things get me down so much. I’d like to get off them eventually, ’cause I don’t like to be on drugs, but I’m not ashamed of being on them. But I don’t think you should be on them unless you get counseling as well, because they won’t do anything by themselves. I was on them for a while before counseling, and that helped a little bit—like I could finally wake up, ya know, and not sleep all day—but it didn’t help me begin to deal with any of my issues.

When I first started taking them I was, like, “I can’t not take them,” and I really felt I needed them to do anything, and I feel like that was part of the placebo effect. But I can feel a difference on days when I don’t take them, or don’t take them until the afternoon, in my level of energy and ambition and stuff. But the counseling is what helps the most, I think. But my goal is to be off all of this stuff when school starts again in the fall—I want to have all my shit together, have money in my savings account. I want to have all those balls in the air, and not be bothered by anybody.

I just see the drugs as a stepstool to help reach the bar, to help you get what you’re reaching for. And I felt like I needed that stepstool—I needed to start to feel good about myself before I could get counseling, and antidepressants helped with that. ’Cause I had spent almost two years feeling pretty terrible about myself, and I needed something to get me out of the negative to above zero in the feeling department. And the ADD medication helped me to stop worrying about all the things I couldn’t control—like, this guy’s life, his finances, his feelings for me—and concentrate on being able to juggle my own life again.

I wouldn’t take any of it back—I don’t wish that none of this had ever happened to me, or that I didn’t have depression, because I think I’m learning a lot from it. And I think it’s showing me how far I can go... as far as caring about somebody, without falling off the edge, and caring too much.

Postscript: You Never Know

I saw Avery’s narrative as incomplete without the story of her rape—but to her the narrative was whole despite, or maybe because of, that omission. She had construed her narrative of her depression and herself where the rape has little or no part in who she is, how she suffers, and how she wants to be.

If at all, the rape exists in Avery’s narrative by virtue of its enormous absence rather than its presence. Like a distant planet or black hole, the rape is discernable in her universe mostly by the way it distorts the perception of surrounding features. Light is bent around its dense mass, and we are left with an oblique image that only hints at what, in passing, has given it shape.

But then, that I was drawn to the gravity of that experience didn’t mean that Avery needed to fall into it herself. The story she constructed characterized the loss of control, the loss of identity, and the loss of self-sufficiency as the important features of her depression. Consequently, her recovery could be characterized by the reclaiming of control with its attendant sense of self-sufficiency and sense of familiarity that control engendered.
I was left with so many questions: What room was there to worry about meaningful relationships, once Avery had relaunched her 35 balls and fixed her eyes on their whirling progress? I saw this juggling act as a means of distraction; when, and how, did she learn to do it? When did Avery become a master of worrying about people without becoming too involved? Did the rape teach her, or reinforce her belief, that it is dangerous to get too close to others? Or neither? What does closeness mean to Avery, and how is it related to vulnerability?

I finally accepted that I would be frustrated in my wish to know what Avery thought about these things and how she might respond to my interpretations. I would be left to speculate about what had happened to her—to me, a four-day hospitalization for “issues with medication” suggested an attempted suicide, either from overdose or as a result of an abrupt withdrawal from the drugs she relied on—but these speculations wouldn’t be verified or refuted. I wonder how far Avery is now from her imagined recovery, and how it will be for her if she ever attains it. It’s hard not to look for her face in the punk-haired women I see and wonder how things will turn out for her. I miss her, and I worry about her, and I wish her well.

Afterword

At this point, I have a confession to make.

Though I prepared for these interviews with the desire—in the spirit of feminist reflexivity and cooperation—to make my bias known to the participants from the start, I eventually decided not to do so at the beginning of the interviews. At first I felt awkward and worried if my bias contrasted too much with the other woman’s beliefs it might inhibit her responses or make the conversation defensive. After the interviews began I realized the dilemma wasn’t so simple as that, for with each story my bias changed as my understanding grew more broad. Even though I wanted to be transparent about my bias, I was no longer clear what it was, and really was more aware of its gradual transformation than its actual shape or dimensions. So I continued to keep mum, though I kept tabs on the change in my bias along the course of the narrative investigation. Its modification, I guessed, was not so much a difference in stance as an outgrowth of shoots, sprouting from my original position to touch the ground of other experiences. It became more complicated, and convoluted, and as my understanding of others’ experiences grew my outlook spread over a wider area and rooted in new soil.

The voice of my bias, too, changed along with its shape: My narrative presence changed to accommodate an increased willingness to understand the different experiences women were having from their point of view. In Lila’s story, my narrative had a direct and definitive presence; the story was told from my point of view, though it incorporated her words and writing. My eventual comprehension of the differences in our perceptions of her world shook me, and in the next story I felt compelled to describe Kylie’s experiences from her point of view. I used more of her actual words, but the story was again flavored by my understanding of her experience, as I tried to recreate my impression of the distancing and numbing effects of her antidepressant experience through a distanced, pale tone of written voice. By the time of Jenny’s and Avery’s interviews I felt more able to submerge myself in their experiences, and their stories were composed almost entirely from their transcribed interviews, with little description or explanation by me. I added a few words to clarify contextual ambiguities, and rearranged the sentences to form sections according to subject, or to represent external versus (eventually external but initially) internal monologue.
By the end of the interviews, I felt confident and familiar enough with the women to share this transformation with them, beginning with the bias that had initially directed my investigation and ending with the complicated, multiple-viewed understanding that was less conviction of a point of view than the comprehension of a sphere of perception. Though I spoke with them each individually, I like to imagine them all together for this conversation, as it was their combined experiences that added eyes to my original point of view.

'Fessing Up: The “F-word” Conversation

There they were: Lila, in her wheelchair still but sans dogs. Kylie sat next to her and spoke excitedly, glad for the opportunity to talk to other women and share her experiences. Jenny hunched next to Kylie, holding her hands in her lap and her thoughts to herself. And Avery’s chair, unfortunately, empty. I took a deep breath and made the plunge.

“I came into this study with, um, a certain stance—one of the things I wanted to do was a feminist analysis of women and antidepressants, and the idea I had when I started was: When women take antidepressants, does that make them more or less aware of the circumstances in their lives that may be disempowering and depressing them? Does it help them cope, or does it help them ignore the things that are causing them pain? And part of the ethic of my research was to be up front about this bias all along, but, ah, it’s really freaky to do that.”

Lila shifted in her seat and looked blank. Jenny pursed her lips together and remained silent, though she met my eye. Kylie burst forth.

“I can imagine! I wouldn’t have known that’s what you thought. But it’s funny that you shared that now, about—I don’t think it would have changed what I said, because I tell it like I see it anyway.”

“I probably wouldn’t’ve,” Jenny said quietly.

One strike for and against, I thought, and continued. “What I found, really, was that my bias underwent a sort of sea change. Which is the way it should be in feminist research, I think, that the researcher is as open to the possibility of the experience changing her as she hopes the participants will be.”

Jenny pinched her lips at the word “feminist” again, and Lila only murmured “OK.”

“What I ended up with,” I went on, “was a point of view that changed from a single bias to a way of looking at this thing from many different ways: the feminist perspective I mentioned”—I watched Jenny twitch out of the corner of my eye as I said this—“and the cultural, medicalized perspective we talked about a little in our individual conversations, and each of your own personal stories about depression, which summed up your experiences better than either of those single perspectives could have done.”

“Was it hard to come back to us with your versions of our stories?” Kylie asked.

“Yes and no. I spent a lot of time going over our conversations, and by the end of that time I certainly had come to my own personal understanding of your story—and I admit I was pretty attached to my own understanding, by then. But it was important to me,” I watched for the flinch, “to do the feminist researcher thing and give you the chance to see what I’d done with your lives.” Jenny’s eyes watered as she met my look, but she seemed to be getting used to the word.

“I think you got me pretty well,” Kylie offered, ever supportive. “But I liked the chance to, you know, put you right if I needed to.”

“It seemed alright,” Lila remarked.
Jenny spoke directly to me, softly. “I think a lot of what you said was true, and some of it I hadn’t thought of that way before. Like, about the agenda being linked to the control I didn’t have in my childhood. One of my counselors had actually mentioned that, too, but I had forgotten until you said it again. I guess it makes sense, in a logical way. But I still think that my problem was chemical, and hereditary. Lots of people have similar burdens as I did, but not everyone is bothered as much as I was. And I think other people can handle things better. I think that argues for a medical condition, but I guess if that’s the way God made me I’ll cope as best I can.”

We were all quiet for a moment. I knew how hard it was for Jenny to talk like this in front of other people, and I ached for her. The little bird had taken the chance of alighting close to find, instead of seeds, needles and glass in my outstretched hand.

“That’s an important piece of your story, too,” I said at last.

“Does it go into your report, then?”

“Yes,” I answered. Jenny held my eye for a moment longer, then seemed to relax.

“How,” Kylie piped up, “do you decide what is the most important thing to talk about? Do you figure out what we all have in common, and write about that?”

I shrugged. “I don’t. I guess my point was to pull out as many different details from your stories and show them all together, not try to blend them all into one general point. It’s like how my point of view went from something sort of certain, and simple, to something that had to look at depression from a lot of different ways. I guess I’m trying to use your stories to draw a picture of depression from a lot of directions at once.” This description brought to mind one of those Cubist still-lifes, all exploded violin parts and faceted oranges arrayed on a dimensionless table. Is that what my picture of depression would end up looking like?


“How do you come to any conclusions, then?” Jenny asked.

“I don’t. Or actually, I don’t come to a single conclusion, but I come to many different conclusions. And if I can do justice to these multiple viewpoints, other people who read them will come to more and different conclusions than I did. In the end, it’s a big, messy picture of a big, messy phenomenon.”

We all sat in silence for a moment, then Lila cleared her throat and spoke. “Then what?”

Then what, indeed. Here I had four stories of depression; what did they have to offer in terms of understanding depression and disempowerment in women in general and not just these women in particular? Their stories illustrated those political and cultural contexts of disempowerment that the feminist narrative recognizes as crucial to an understanding of depression in women: Lila’s experiences of disability, being poor, and living in a rural area all contributed to the difficulty she had in getting the goods and services that are more readily available to others. Kylie’s difficulty with deciding to stay at home with her child instead of pursuing her professional career was not mitigated by an option for childcare services at her workplace, which, had it been available, might have given her more of the time she wanted to spend with her child without making her have to choose between her daughter and her job. Jenny lacked a ready explanation for how her experiences with sexual abuse might have affected her, though she was exposed to many campaigns for pinning her agitation and disappointment on her brain or her woman’s body. And Avery, who had her sexuality, her money, and her love stolen from her, couldn’t begin to replenish these things; she could only envision regaining power through the recovery and the miserly hoarding of these resources that she had otherwise exercised power through sharing.
These circumstances of disempowerment were important enough so that the women framed their stories around them. But even though the women acknowledged the sadness, pain, or even tragedy of their lives, they neither considered these events disempowering nor judged the events alone reason enough to be depressed. The medical narrative they subscribed to gave “illness” that power. It was striking that in these stories the women did not question why they should have to suffer rape, or sexual abuse, or poverty, or discrimination. They questioned, if anything, their inability to cope with these disempowering events, and viewed consuming antidepressants as a means to correct that deficiency.

How had the medicalized narrative assumed so much power over these women? And how had a psychological phenomenon of emotional life become a medicalized phenomenon of physical deficiency? How had the medicalized narrative become the master narrative with which the women structured their stories?

Power and the Master Narrative

In psychology there is an underlying similarity between many of the foremost theories (or psychological narratives) that seek to explain depression, especially depression in women: They all assume, at some level, an internal flaw possessed or perceived by the sufferer.

The cognitive narratives call this flaw helplessness. In the narrative of learned helplessness (Abramson, Seligman, & Teasdale, 1978; Seligman, 1974), a person attributes her negative life events to her own inability to effect change. The cognitive narrative of helplessness and hopelessness (Abramson, Metalsky, & Alloy, 1989; Beck, Rush, Shaw, & Emery, 1979; Riso & Newman, 2003) explains that a person becomes depressed when she understands that not only is she unable to handle or change these life events, but that she will also continue to be plagued with them. In the cognitive narratives, the internal flaw applies both to a person’s (flawed) tendency to see events in a negative light and her propensity for attributing the cause of that negativity to her (flawed) self; her negative attributional style is expressed in internal terms.

Gendered narratives of depression take into account the effect of women’s ways of relating to their world on their depression. Nolen-Hoeksema links the cognitive internal flaws of helplessness and hopelessness to a woman’s potential gender role, when she takes on a more “feminine,” less assertive role (helpless), and has lower expectations of control over important events (hopeless) (Nolen-Hoeksema, 1990; Nolen-Hoeksema & Girdus, 1994). In this narrative of gender norms, the feminine trait of rumination is linked to her helplessness, for the internal flaw that makes a woman unable to act or distract herself (distraction by activity is considered a masculine trait) causes her to brood instead. In Jack’s (1991, 2003) narrative of “self-silencing,” a woman might become depressed when her thoughts and emotions are understood by her to be flawed and must be denied or “silenced” in order to not threaten her relationships, jobs, or way of life. She might “mystify” the cause of her troublesome emotions, attributing them to some flaw in herself in order to avoid the danger of attaching them to a situation or relationship she wishes to maintain; if she fails at this task of silencing and displacing her emotions, the resultant guilt and feelings of inadequacy may further contribute to her depression.

The medicalized narrative describes the internal flaw in such a way that it subsumes all these psychological narratives: A person is helpless because of an internal flaw of brain chemistry, and her cause is hopeless because her flawed condition is unremitting (a narrative of chronic disease). In the medicalized narrative, the absence of troubling emotions (“silenced”
problematic feelings) is equated with the absence of depression; the narrative promotes the “silencing” or dulling of emotions, as doing so inhibits rumination and allows for distraction. The promise of remedy in the medicalized narrative translates the problem of internal flaw into a consumer fix: antidepressants. The medicalized narrative answers helplessness and hopelessness with its “corrective” prescription drug, which offers help and hope for as long as it is consumed. This correction of flawed brain chemistry is perhaps not empowering as it is enabling. It allows the person to continue living with the status quo by helping her to not feel emotional about events she would otherwise consider upsetting. In doing so, it promotes the depressive state of one narrative (“silenced” emotions) as its own “cured” state. At best, the medicalized narrative’s remedy lends power to its consumer, but in this narrative power to change must always be understood not as an attribute of the self but as a benefit of the drug.

The subsumption of these psychological narratives, and by implication all psychological narratives, makes medicalization a very powerful master narrative of depression. As a master narrative it has great cultural currency: Its vocabulary (e.g., brain chemistry, chemical imbalance, SSRI, neurotransmitter, etc.) is part of the common public discourse. The consumer potential inextricably embedded in medicalized depression makes it the darling of the for-profit health industry; the enormous wealth of the drug industry has and will continue to promote this lucrative narrative. The omnivorousness of the master narrative in its consumption of other narratives, the fluency with which it is told among ourselves, and the financial potential inherent in its promotion all add to its considerable power and as such affects how we learn, think, and speak about depression.

Medicalized and Feminist Narratives

Feminist narratives of depression share recognition of the importance of environmental factors with psychological narratives of depression, though those narratives may see external factors as “stressors” that aggravate an inherent weakness rather than as disempowering forces in themselves. But though the feminist narrative shares this point of similarity with the psychological narratives subsumed by the master tale, there remains a fundamental incompatibility between the medicalization of the master narrative and the feminist depression narrative. The master narrative rests on the assumption that depression results from an internal, personal flaw, while the feminist narrative underscores the power of a politically, culturally, and personally disempowering environment in one’s distress.

These women’s stories amply illustrate the conflict between these two narratives. Their consumption of antidepressant drugs for their distress showed a possible acceptance of the master narrative. This acceptance was then made explicit by matter-of-fact description of the cause and course of their depression in the common terminology of the medicalized narrative.

Facets of the psychological narratives can be found in the women’s stories, though they spoke of these things in a form and parlance borrowed from the master narrative: Lila felt helpless to care for herself and her family the way she would like and lacked hope that things would ever get better for her. But when she wrote “[I] cry a lot, horrible temper, at times hard to live with,” she continued to explain “but is [I] reckon, chemical imbalance of my brain causing [a] lot now.” Her grief and sadness about the loss and dysfunction of her family, and especially her anger about that dysfunction, were framed in her story as symptoms of a disease that needed “curing” (to be silenced). Indeed, the silencing of anger especially was a recurrent theme in the women’s narratives: Kylie “mystified” (Jack, 2003) her anger, displacing it to her child and
ultimately viewing it as the cause of her unhappiness and not its byproduct; Jenny mystified her anger, too, tying the experience to the success or failure of her control over her “agenda.” Avery’s anger was so silenced as to be inapparent: She voiced no anger at her rapist for “taking [her] from zero to a hundred in the sex department,” at her married boyfriend for “using [her], I guess,” or at her subsequent sexual partners for being content to let her “just [be] there for them” while she disconnected, “hovering above the situation,” not wanting to feel anything. In these stories, anger was talked of as a troublesome symptom of a disease, an especially difficult one that the women used the antidepressant to remit.

When women speak of their depression in these terms, culturally and politically disempowering events targeted by feminist narratives are not seen as problematic; instead, the women’s inability to cope with these events (because of their internal flaw) appears as the crisis in their framing of their stories. Couched in terms of the master narrative, contexts of personal disempowerment—such as the inability to acknowledge the tragedy of a dispersed and negligent family, reluctance to grieve one’s past, and feeling wrong to be angry about rape and abuse—are also described as problems to cope with rather than redress. In these stories, despite descriptions of feeling “better” each woman acknowledged a residuum of pain that she could not reconcile with her recovery. In what ways might they have made sense of this remaining pain—and chosen to deal with it—if they had other ways to talk and think about it than as an uncorrected flaw of brain chemistry?

**Personal Narratives and Future Research**

Though these are only four of countless women’s stories, this collection of narratives highlights the conflict between the master narrative of medicalized depression and personal narratives of disempowerment. The thick description in the stories provides details that bring to light the more problematic examples of disempowerment in depression, including those that are subsumed, mistranslated, or left out by the master narrative.

In doing so, these narratives fulfill the two basic contributions expected of research. Adding to general knowledge is the first of these expectations, with the narratives’ depth contributing something different to the fine-tuned but necessarily circumscribed understanding of empirical research. Because these stories communicate a wealth of detail, they show how the master narrative swallows points and parts of many different theories, hypotheses, and models. They illustrate how these points are translated into the vernacular of the master narrative, bloating it; they indicate how when the master narrative gains so much power it overwhelms and shapes personal understanding.

The second function of research is to ignite passion: we research what we care about, and what we want to make others care about. Worthy topics that incite outrage can fuel inventive, innovative, and imaginative examination. Some peoples’ passions to do this are kindled by literal figures, but others catch fire from the inflammatory experience of literary immersion. These stories provide the opportunity to become engulfed in the details of this problematic experience, to gain new and different perspectives, and to be moved to question how else people might suffer when they accept the limitations of a dominant narrative.

When pursuing future research on personal experience in the context of medicalization, it will be important to address a number of remaining issues. It is difficult to discuss the limitations of the medicalized narrative without undermining the choices made by women who use antidepressants. Future dialogues must serve to describe how medicalization can dictate the
course of women’s negotiation of their depression: by normalizing it, or by overwhelming other ways of understanding it, or by simplifying its treatment. But the description should not present women as mere dupes of the master narrative. If the medicalized narrative is understood as locating the problem and cause of depression in the body, there are possible non-medicalized narratives of antidepressant use; for example, wherein women recognize the effects of cultural, societal, or political disempowerment on their depression and use the physiological effects of the drug to help them negotiate these disempowering contexts.

Pursuing more stories of antidepressant use may serve to illustrate how some women resist the self-blaming message of the master narrative, constructing their own understandings of depression by borrowing themes from other narratives as they see fit. When more of these stories are brought to light it may become more clear how a woman might be encouraged to navigate the challenges in her life in a self-determined manner, using whatever means at hand—therapy, life changes, antidepressants, activism, etc.—to understand her depression in a context that empowers her to overcome it. These stories, in turn, can help to defuse the disempowering idea that depressed women suffer only themselves; each recovery born of such understanding helps dismantle the disempowering structures that frame women’s depression.
References


Women and Depression
Are you currently taking a prescription antidepressant? I would like to hear your story.

I am a Clinical Psychology graduate student, and I am interested in talking with you about your depression and your experiences with medical antidepressants as a part of my research into the treatment of depression.

I am seeking women 18 years of age and older for a series of 2 to 3 private, confidential interviews on the topic of their experiences with depression.

All information is confidential; financial compensation will be provided.

For further details please contact Siri at:
(513) 330-2166
or
womendepression@hotmail.com
STUDY TITLE: Voice of the Drug: What Antidepressants Tell Women about Their Depression

PRINCIPAL INVESTIGATOR: Siri Hoogen
FACULTY ADVISOR: Roger Knudson, PhD

The purpose of this study is to examine how women come to understand the reasons for and the sources of their depression after they undergo medical antidepressant treatment. It is hoped that the sharing and examination of personal experiences with depression will help both researcher and participants come to a greater understanding of how women’s views about their experiences with depression may be shaped by medical antidepressant treatment.

Participants will engage in a series of 2 to 3 one-on-one interviews of 60 to 90 minutes duration each. At least the final interview will include the presentation the researcher’s work with the participant’s interview material for the participant’s review and critique. Following this, participants may indicate if they wish to be contacted at a future date for possible follow-up interviews for further investigation of this issue.

Participants will be compensated at a rate of $10 for up to the first hour of interview time and for every subsequent hour or fraction thereof ($15 for 90 minutes, $12.50 for 75 minutes, etc.).

Participation is strictly voluntary and participants may decline to participate in any interview at any time during this study. There will be no penalty for discontinuing participation. There are no foreseeable risks for participating in this study, although talking about certain experiences may be upsetting to some participants. Participants are encouraged to contact the Miami University Psychology Clinic (529-2423), The Community Counseling and Crisis Center (523-4146), or Miami University Student Counseling Services (529-4634) if they experience distress. There is no deception involved in this study.

The confidentiality of participants will be protected. Only the primary investigator will have access to the names of the participants. All participant-generated material, including audiotapes, videotapes, and transcripts will be coded with a pseudonym. The only other people who may have access to the coded materials will be the principal investigator’s faculty advisor and/or her student research assistants involved in this project. Audiotapes and videotapes will be kept in a locked cabinet for the duration of the study, after which they will be destroyed.

If there are any questions regarding this study, please contact Siri Hoogen at 513-330-2166 or at sirhooog@hotmail.com, or her faculty advisor, Roger Knudson, at 513-529-2404 or knudsorm@muohio.edu. If there are any questions regarding the rights of research participants, contact the Miami University Office for the Advancement of Scholarship and Teaching at 513-529-3734.

I have read the preceding statements and agree to participate in this study.

Signature of participant      Date
CONSENT FOR RECORDING AND QUOTING INTERVIEWS

STUDY TITLE: Voice of the Drug: What Antidepressants Tell Women about Their Depression

PRINCIPAL INVESTIGATOR: Siri Hoogen

I understand that the interviews I participate in will be recorded on audiotape and videotape. I further give my permission for the researcher to quote from the interviews in any reports of this research (including papers presented at professional conferences, articles in professional journals, or book chapters). I am free to withdraw this consent at any time for any particular interview or for the entire set of interviews. There is no penalty associated with withdrawing this consent.

I consent to my interviews being recorded on audiotape and quoted as described above.

________________________________________  ________________________
Signature of Participant               Date

While my image may be recorded for ease of transcription of the interviews, my image and the image of my personal surroundings will not be shared visually beyond the principal investigator, her advisor, and her research assistant.

I consent to my image being recorded on videotape and used for transcription purposes only as described above. I am free to withdraw this consent at any time for any particular interview or for the entire set of interviews. There is no penalty associated with withdrawing this consent.

________________________________________  ________________________
Signature of Participant               Date
Interview Questions for Qualitative Research

Conditions of diagnosis and treatment decisions:

1. What kinds of things were going on in your life before you were diagnosed with depression? What were the things that upset you?
2. What made you finally decide to seek help for depression?
3. Who diagnosed you with depression—did you have some idea what was wrong before you saw a doctor or a therapist? How did you come to seek professional consultation?
4. Who brought up the idea of a prescription antidepressant? Was it your idea—if so, how did you become familiar with antidepressants to know what to ask for? If it was your doctor’s recommendation, how was it presented to you? Did you feel you had any choice about taking the prescription?
5. Did you discuss any possible alternatives to a prescription antidepressant [i.e. therapy] with your doctor?
6. Have you talked with a counselor before?
7. How do you feel about taking antidepressants?
8. Who in your life knows you are taking antidepressants, or knows about your diagnosis?
9. Have you tried a number of different antidepressant medications?

Identification of interpersonal and intrapersonal problems contributing to depression:

10. When you were first depressed, before you started taking antidepressants, what did you hope would change in your life—what differences in your life (outside of yourself) did you think might make you feel better?
11. Now that you are taking antidepressants, have some of those things started to change?
12. Now that you are taking antidepressants, have you identified new changes you would like to make in your life?
13. What kind of personal, within-yourself things—moods, activities, feelings about or strivings in your life—changed when you started taking the antidepressants?
14. What kind of personal things—moods, activities, feelings about or strivings in your life—didn’t change when you started taking antidepressants?
15. Do you feel better equipped now to deal with events in your life that trouble you?
16. Do you feel better equipped to try to change the situations in your life that trouble you?

Questions of depression’s effect on life’s trajectory and inertia:

17. Before you became depressed, what were some of your goals or dreams in life?
18. Did your goals or dreams change as you became depressed?
19. Since you began taking antidepressants, have you accomplished or do you feel closer to achieving your goals? Have you begun to make new goals in life—what are they?
20. Are you content with where antidepressants have brought you now? Is there more that you want to gain from antidepressant treatment, or are you content with where you are?
21. Is there something you think antidepressants might not be able to give you—are you ok with that?
22. Do you envision a time when you will not take antidepressants?

The effects of depression and antidepressants on personal identity:

23. What kind of person did you see yourself as before you became depressed? Who were you?
24. How, or did, becoming depressed change how you see yourself? Who is the depressed you?
25. When you began taking antidepressants, how did you see yourself? Who are you now?
26. Who would you like to be? Is there a viable possibility that you can become that person—what or who will help you get there?

Ideas about depression:

27. Would you recommend antidepressants to any of your friends or family? Why?
28. Is there a reason for your depression, or for anyone’s depression?
29. Can you, or will you, ever overcome that reason? How can others?
30. Do you think it’s normal to feel bad about the things you do?
31. Why do you think women are depressed more often than men? What kinds of things tell you that depression is normal for women?