YOUNG ADULT WOMEN AND THE SOCIAL CONSTRUCTION OF DEPRESSION:
A QUALITATIVE STUDY

DISSERTATION

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By

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* * * * *

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To My Mother and Late Father
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CHAPTER I
INTRODUCTION

Circumstances and conditions that American society has come to accept as normal or ordinary lead to profound unhappiness, anguish, and mental illness in women. (President’s Commission, 1978, p. 1038)

Background and Setting

Depression is a complex and often misunderstood mental illness. While most experts agree that depression is a group of mood disorders with different symptom patterns and varying degrees of severity, they remain unsure as to how many patterns of depression exist and how to distinguish them (Rosenfeld, 1985). The DSM-III-R reflects this complexity and uncertainty by outlining at least 15 depression related diagnoses (American Psychiatric Association [APA], 1987). Nevertheless, depression is one of the most common mental disorders in Western societies, and its frequency appears to be increasing (Bromberger & Costello, 1992). The illness threatens such a significant portion of the population that, according to Munoz (1987), "depression costs the United States an estimated 16.5 billion dollars per year. Of this amount, approximately
three billion dollars are treatment costs, and the rest indirect costs, such as lost productivity" (p. 4).

**Basis for Study**

Women are diagnosed with depression at almost twice the rate than men (Newmann, 1987; Ridsdale, 1986; Sidel, 1986). This is one of the most consistent findings in the literature (McGrath, Keita, Strickland, & Russo, 1990). In epidemiological studies of depression, the prevalence rates appear to range from 1.9 to 5 times as many women compared with men suffer from depression, thereby confirming that women are at least twice as likely as men to suffer from "a major depressive disorder" (Bromberger & Costello, 1992, p. 121). The difference holds for all races of women when variables of income, education, and occupation are controlled (McGrath et al., 1990). Other countries report similar 2:1 ratio of depressed females to males; however, there are some notable exceptions such as India, Iraq, New Guinea, and Ghana (Al-Issa, 1980). In fact, the ratio in India is reversed such that twice as many males than females are diagnosed with depression (Al-Issa, 1980).

Many factors have been considered as possible explanations for women's higher rates of depression. Some of those researched associations include women's higher vulnerability to depression (Newmann, 1987); the family roles that women occupy (Aneshensel, Frerichs, & Clark,
1981); women's marital status (Thoits, 1986); and learned helplessness (Kiefer, 1990), to name just a few. Nevertheless, no associations or combinations of variables appear to provide the complete explanation for these higher rates. Gender differences are also not adequately explained by differences in seeking help or willingness to report problems (McGrath et al., 1990). Furthermore, men and women share some of the same risk factors for depression. Genetic, biochemical, and hormonal factors are some of those same risk factors as are parental psychopathology, personality, stress from negative life events, circumstances and loss (McGrath et al., 1990). Consequently, these known risk factors do not adequately explain the differential either. The question remains, why are women more likely to be depressed more often than men? Perhaps the answer is as simple as diagnostic bias or as complex as an interaction of biological, social, and personality factors. Regardless, researchers simply do not have a complete understanding of the etiology of women's depression such that it differs from men's depression. For that reason, perhaps the question should be, what is it in the daily lives of women that causes so many of them to become depressed?

Justification for Study

In general, most explanations of depression have emphasized the role of women and the individualistic,
idiosyncratic, and innate qualities of women, rather than the greater social problem of sexism and the oppression to which women are subjected (Sidel, 1986). For example, one of the latest pieces of compiled research suggests that women's depression is related to certain cognitive and personality styles. McGrath et al. (1990) states that "women tend to be avoidant, passive, dependent, pessimistic, and have negative cognitive styles" (p. xii). Perhaps we need to consider why women may have these attributes and/or negative cognitive styles. One rationale may be that women continue to be constrained by the prevalent sexism in society and the subsequent oppression in their daily lives. It is difficult to be strong, assertive, optimistic and positive when one's socialization and life circumstances keep an individual from achieving her full potential and happiness. Thus, the true etiology of women's depression remains uncertain.

As alluded to previously, another point that needs consideration is how the diagnosis of depression is determined. Many professionals rely on the DSM-III-R, a widely used document in the mental health field, to assist in determining and labeling mental illness. Unfortunately, the DSM-III-R is thought to use a "male-centered" definition of mental illness (Tavris, 1992). In other words, the behaviors and attitudes that determine who is mentally ill and who is mentally healthy are defined by men such that
behaviors considered normal in men may be considered "crazy" in women (Richardson, 1988). For example, women who place greater importance on their work than on their families, hide their feelings, or put their own interests above others are labeled mentally ill; men who do the same are not labeled as such. There is clearly a double standard of mental health. Consequently, it may in fact be that women are labeled as being depressed when they are simply responding to their environment and situations in a particular way. Most research on depression has centered on therapists' perceptions of who is depressed while few studies have directly asked women about their own diagnosis of depression. In contrast, this study will allow women to self-diagnose their depression, given the possible biases in diagnoses by therapists.

Another possibility for women's higher rates of depression may be that depression does not manifest itself in men the same way it does in women. After all, men and women do share many of the same risk factors, as noted previously. It has been suggested that men deal with depression by abusing substances or other acting out behaviors (Gove, 1979). In short, gender differences in depression could be explained in that men externalize their expression of depression and women internalize their expression, thereby accounting for differences in diagnoses of depression. On the other hand, many men manifest
depression in the same way that women do, with a depressed mood, fatigue, feelings of worthlessness, etc. This possibility will be discussed more later but for the purposes of this study, we will focus on women's etiology of depression.

Major Research Questions

To yield some new insight into the etiology of women's depression, this study will consider both the "inner selves and outer lives" of women (Jack, 1991). Through an inductive process of listening to women's perspectives on their lives and their depression, I believe that information will emerge that may have previously been overlooked by researchers or overshadowed by many of the more established theories. Thus, the major research question for this study is, what is it in the daily experience of young women that leads so many to feel depressed? It has been suggested that depression is "incorporated into the fabric of women's lives" (Nairne & Smith, 1984, p. 104). For example, it is considered "normal" for women to feel depressed after having a baby or after breaking up with a significant other. Furthermore, friends, doctors, the news media, and others often confirm the normality of depression in women's lives, suggesting that depression is inevitable for women. Given this possibility, depression in women may be socially constructed.
One objective of this study, then, is to have women describe their depression as it manifests itself in their daily lives. Participants will be encouraged to describe how their depression feels, how it affects their lives, and anything else that seems pertinent in their perspective of depression. A second objective of this study will be to consider what young women perceive to be the source of their depression. I believe that women do have some understanding of what creates the depressive feelings in their lives and that there may be some similarity in those beliefs among women. These similarities may establish new associations in the etiology of women's depression. In keeping with these objectives, an inductive, exploratory method will be used as the means for gathering this information.

Generally, past studies of depression have looked at groups of women who were thought to be the most susceptible to depression, such as young women with children or women who are unhappily married or women who have suffered a loss. Likewise, depression studies have considered factors of race and class, and these studies indicate an even higher rate of depression diagnoses among minority, lower class women (Belle, 1990). It is not very surprising that these women would be more likely to be depressed given their constrained and stressful roles, relationships, and social status. In contrast, this study will ask whether a less constrained group of women—young, adult, educated, single women with no
children--have factors in their lives that lead to depression.

Definition of Terms

Feminist Research

Feminist research is "to put the social construction of gender at the center of one's inquiry" (Lather, 1991, p. 71). Thus, feminist researchers see gender as the central point that shapes the conditions of women's lives. In other words, gender influences the shaping of one's consciousness, skills, and institutions as well as the distribution of power and privilege. The goal, then, of feminist research in the human sciences is "to correct both the invisibility and distortion of the female experience in ways relevant to ending women's unequal social position" (Lather, 1991, p. 71). As such, feminist theory and research methods will guide this research project.

Depression

The DSM-III-R describes a major depressive episode as:

A depressed mood . . . or loss of interest or pleasure in all, or almost all, activities, and associated symptoms, for a period of at least two weeks. The symptoms represent a change from previous functioning and are relatively persistent, that is, they occur for most of the day, nearly every day, during at least a two-week period. (APA., 1981, p. 218)

Although this definition is widely used by those in the medical field and the mental health field, the psychiatric
diagnosis of depression lacks clarity. As McGrath et al. (1990) point out, "depression is heterogeneous. It is not a continuum from the 'blues' to major depression and, eventually suicide. Rather, depression varies in kind and in the contribution of different risk factors" (p. xii). McGrath et al. (1990) further suggest that researchers "... maintain the distinction between an isolated symptom of depression and a persistent set of symptoms, or syndrome, since different correlates may be associated with different depressive syndromes" (p. xii). Thus, depression can be thought of as a complex, multifaceted syndrome. Regardless of the definition used, the psychiatric label tends to hide the social nature of women's problems. The definitions of mental illness have often been sex stereotyped because psychiatric diagnoses have been largely developed by male psychiatrists (Sidel, 1986). As a result, definitions may reflect not only a double standard in the diagnosis, but also in what behavior is expected of women in this society (Richardson, 1988).

Furthermore, Al-Issa (1980) discusses differentiating psychotic and neurotic depression in terms of symptoms such as negative interpersonal events and negative subjective bodily feelings respectively or as exogenous and endogenous depression respectively. The problem with identifying some differentiation of depression is whether the precipitating event can be accurately and completely identified. In
short, the definition of depression has never really been adequately or fully defined (Carob, 1987; McGrath et al., 1990). I believe that for women with depression, any kind or degree of symptomatology does reflect considerable suffering. Thus, for this study, depression will be defined by the subjects themselves, assuming that their symptoms, experience, and perception of depression are as meaningful as any given label of depression from those in the mental health field. Moreover, it is not unusual for individuals to diagnose themselves in the sense that we each have some understanding of when we are not well, when we need to be treated, and when we need professional medical attention.

**Oppression**

Oppression can be considered to be the social constraints or discriminations that limit opportunities and choice. It may be that many women feel an inarticulate sense of sexism and its wider consequences. As a result, many participants of this study may not be aware of their oppressed status and may have developed a "false consciousness" of what creates depression in their lives (Lather, 1986). To avoid any imposition or domination by the researcher’s beliefs, I feel that the most ethical way to deal with this phenomena of oppression will be to negotiate the meaning of the depression and what may be the source of the depression with the participant. In this way,
the research will encourage self-reflection and perhaps a deeper understanding of the forces that may create depression. Although this encouragement may be thought of as an imposition, it may also be liberating for women who have been socialized to blame themselves for any mental "failings."

In addition, feminism is committed to social transformation such that changing the consciousness of women as subjects is central to combating this oppression (Weiler, 1988). Thus, for those who choose to maintain a belief that provides direction and meaning in their lives, I will not impose my information or beliefs on the participants. On the other hand, for those who feel the need to know more about any sense of oppression, discussion of oppression may ensue or literature will be recommended.

**Therapy**

Therapy is most often considered to be an established mode of treatment performed by a psychiatrist, psychologist, social worker, counselor, or pastor/religious person. It is thought that many participants in this study will have already had some encounter with therapy in their lives because therapy is readily available to many people, especially young people on college campuses. Consequently, some therapy and labels of mental illness may have already influenced the thinking and belief system of these women
such that they may have developed a particular view of therapy, mental illness labels, causes, and manifestations.

It is difficult to sort out the influence of therapy and socially recognized labels; however, therapy is a part of many women's lives. Gove (1979), for example, found that women were more likely to be treated for mental illness than men. For these reasons, there will be little attempt to sort out what influence therapy may have already had on participants. It is just as likely that the participants will have had their views influenced by the media, family, and friends. As a result, this study will start with where these women are now in their thinking and will not attempt to sort out the many and complex influences in their views.

Basic Assumptions

Several assumptions are made in this study. One assumption, previously mentioned, is that the diagnosis of depression is replete with biases. For that reason, participants in this study will define their own depression. Similarly, it is assumed that not all depressed people seek help for their depression and therefore, do not receive an "official" label for their depression. I believe that those who do not seek help may have a particular belief or view of their mental health, and those who do seek help may have their beliefs of depression altered to fit the viewpoint of the therapist. It is assumed, however, that most of the
participants will have taken part in some therapy at some point in their lives. In either case, therapy will simply be considered part of women’s lives and will not be viewed as a separate factor in each woman’s perspective as it would be too difficult to separate something that is ingrained in women’s lives. For the purposes of this study, then, participants will not be limited to those who have or who have not sought therapy, and the issue will be addressed with the participants.

Another assumption, also mentioned, is that women may manifest their depression in a particular way that differs from men. This study will not attempt to compare that possible difference, but rather, focus on the way women manifest their depression and how that manifestation is tied to the possibly unique etiology of women’s depression. Lastly, it is assumed that these young adult women are able to speak for themselves and their words will be taken without further verification as it is their perceptions that will yield new information on depression in young adult women.

Significance of the Problem

Depression is a serious problem currently affecting at least seven million women in the United States (McGrath, et al., 1990). The number reflects not only considerable personal suffering, but also lost productivity and lost
potential. There are many theories that attempt to explain women's depression, but few of those theories consider a social construction of depression. This inductive, exploratory study will consider the social construction of depression in young, adult women so that a new perspective may be gained as to the reasons for young women's depression and how that depression affects their daily lives. It is hoped that the perspective of the participants will yield not only insight into the etiology of depression in young, adult women, but will also provide clinical, theoretical, research, and practice implications.
CHAPTER II

LITERATURE REVIEW

Since no existing theory adequately explains the complex phenomenon of female depression, a return to depressed women’s own descriptions of their experiences and feelings becomes critically important as a means to gain new insights. (Jack, 1991, p. 2)

Theories of Depression

Many theories or combinations of theories have been used to guide research on depression and help to explain the etiology of depression. The many different theories seem to have arisen out of the complex and varied experience of depression. Consider that in describing the experience of depression, many women note a wide range of symptoms that may include emotional, social, or physical symptoms. Most theories tend to focus on a particular aspect of depression, such as its cognitive manifestations, physical symptoms, or environmental influences.

Research based on these theories of depression spans across several disciplines including social work, medicine, psychology, psychiatry, nursing, and sociology, such that each discipline tends to be invested in a particular theory or set of theories. Unfortunately, by focusing on one
aspect in one discipline, a fragmented picture of a complex, non-linear illness is created. It would seem, then, that a more complete and insightful picture of the etiology of depression would emerge if all of these different theories and findings were considered. This review will attempt to summarize the major theories and findings across several disciplines in order to bring an understanding of the perspective chosen for this work that will be outlined in the next chapter.

**Psychoanalytic Theories**

In psychoanalytic theory, human behavior is motivated by drives and needs that are unconscious. Freud’s drive theory suggests that there are two primary drives that motivate human behavior: libido, which refers to all biological drives, and aggression (Brenner, 1974). Freud argued that when we love another person, we invest our libidinal energy in that person. Given this notion, it is thought that depression arises out of one’s inability to transfer libidinal energy from a lost love object to another object, thereby turning that energy inward onto one’s own ego (Nolen-Hoeksema, 1990).

Freud’s stages of development relate to these motivations in that during different stages, a child has different tasks to resolve or master. Freud believed that those most prone to depression are those dealing with
unresolved conflict in the oral stages such that people who suffer from depression are now fixated in this stage (Hartmann, 1958). As adults, these individuals continue to be dependent on others to take care of those unmet needs, particularly the biological drives/needs. On the other hand, people may not be fixated in a particular developmental stage but may regress to a stage in response to a loss. In this case, depression would be greatest in people with oral-dependent and narcissistic personality traits or more simply, those excessively dependent on others (Nolen-Hoeksema, 1990).

Sands (1991) notes that ego psychology is a reconstruction of Freud's psychoanalytic and structural theories such that the emphasis is on the reciprocal relationship between the person and his/her environment. In ego psychology, the ego does more than reality testing and mediation. Instead, the ego organizes, forms object relations, and promotes adaptation. In addition, ego psychology builds on and reinterprets Freud's drive theory such that the two drives, libido and aggression, are thought to be complementary. Later theorists postulated that there is a third source of motivation, a striving for competence that does not emanate from the two drives. This motivation is exemplified in exploration, manipulating objects, and mastery (Sands, 1991). In other words, all people seek to
have an effect on their environment; when they do not, they may be at risk for depression.

Also, coming out of psychoanalytic theory is object relations theory, shaped largely by Karen Horney (Nolen-Hoeksema, 1990). In object relations theory, an infant develops into a "social being" in the context of social interactions with significant others. Through an interpersonal process, the ego incorporates representations of the self and significant others into the self. As infants develop, they form mental images (internal representations) of themselves and others, which allow them to carry significant others and others' images of themselves with them (Blanck & Blanck, 1986). Failure to form these mental images may lead to a sense of loss, and then to depression over that loss.

Personality development theory has also grown out of psychoanalytic theory (Nolen-Hoeksema, 1990). "Personality is usually conceptualized as a set of attitudinal and behavioral characteristics that a person shows consistently in many situations across time" (Nolen-Hoeksema, 1990, p. 105). Once again, Freud's psychoanalytic theory of personality is considered the classic personality theory. Freud argued that biological drives interact with early childhood experiences to create traits. He felt that females develop a set of traits such as passivity,
dependency, and a tendency to be self-sacrificing, all of which predispose women to depression (Nolen-Hoeksema, 1990). Many personality trait theories attempt to link assertiveness, influenceability, risk taking, and/or helplessness to women’s predisposition to depression. In the case of assertiveness, there is not substantial support for the claim that women tend to be much less assertive than men (Nolen-Hoeksema, 1990). Likewise, others suggest that women are more likely to be dependent and are more concerned with relationships than men; however it may be that women are simply more socially oriented or that men and women may value different aspects in relationships (Nolen-Hoeksema, 1990).

Other personality characteristics have been thought to be linked to depression. For example, men and women seem to differ in their personal responses to depression. Ruminating has been found to enhance and prolong depression and pessimistic explanatory style also enhances and prolongs depression (Nolen-Hoeksema, 1987). Women tend to do the former while men often use distracting behaviors such as thinking about other things, ignoring the problem, and engaging in physical behavior. This behavior may be a factor of socialization such that men and women learn different response styles. This point will be discussed with other socialization issues in the following sections.
Thus, in psychoanalytic theories, depression arises out of an individual’s inability to reconcile conflicts or personality defects. The theories suggest that the cause of depression is within the individual and that to alleviate depression, there has to be some understanding of the individual’s past to make some changes in the individual’s present and future. While the theories do center on the individual and individual failings, the theories also touch on other factors that have been linked with depression, most notably loss, socialization, and behavior. Those other factors will be considered in the following sections.

**Behavioral Theories**

Behavioral theories are concerned with environmental events or conditions that surround behaviors (Sands, 1991). These theories assume that regardless of whether behaviors are adaptive or maladaptive, they are learned. Three major approaches within behavioral theory are respondent conditioning, also known as classical conditioning; operant conditioning, also known as instrumental conditioning with an emphasis on consequences; and social learning theory in which observational learning is emphasized. Depression is considered by most behaviorists to be a motivational deficit that is associated with a lack of social skills and little reinforcement. With little reinforcement, individuals do not act on some stimuli and become passive in their
response. As a result, some people develop "learned helplessness" or the belief that one has no control over the environment (Seligman, 1975). When opportunities arise to do something about a situation, the response is passivity and depression. Learned helplessness may also be considered a social construct in that society shapes people into having a greater vulnerability to depression (Sands, 1991). Similarly, depression may result from traumatic life events (provoking agents) and the ensuing inability for the individual to cope because that "skill" was not learned.

Social learning theory is also a behavioral theory in which observational learning is emphasized (Sands, 1991). The theory is associated with Bandura (1977) and makes use of the principles of classical and operant conditioning. Social learning theory moves behavioral theory toward increased attention to cognition by suggesting that behavior can be acquired by observing others or events. Observers learn by watching, listening to or reading about "models" or other individuals. Observing can also include learning about the consequences perceived to occur. Social learning theory is guided by the principle of "reciprocal determinism" which is the three way interaction among the behavior, the environment and internal events. Thus, depressive symptoms may be a learned way to garner attention and sympathy, or even a passive way of striking back in a more socially acceptable way (Richardson, 1988).
Behavioral theories also cover the direct reinforcement of sex-typed behaviors. Nolen-Hoeksema (1990) writes that there are no underlying traits that are innately more prevalent in one gender, but rather, that boys and girls are rewarded and punished for particular behaviors, behaviors that lead to sex role socialization. For example, parents encourage children to play with particular games; boys are encouraged to play "war" and girls to play "house." Likewise, parents seem to respond more quickly to girls' requests for assistance than to boys' requests. Bandura (1973) furthers this point by noting that children learn sex appropriate behaviors by watching adults, particularly same-sex parents. Furthermore, peers and teachers have great influence over the behaviors of boys and girls. Thus, consequences and rewards for gender appropriate behaviors can be learned through both observation and interaction.

A related theory is cognitive/behavioral theory. This theory suggests that people are inconsistent in their behavior in different situations and that people tend to act according to the rewards and punishments that will result from their actions (Sands, 1991). Cognitive behaviorists believe that people think about their situations, form expectations of consequences, and then think about causes and implications of those events. As a result, people's perceptions and beliefs about situations affect their behavior such that those who suffer from depression, tend to
behave in a "depressed" fashion. Similarly, the consequences and implications of one's behavior can affect future behaviors so that an individual may be more cautious, passive, hopeless, or helpless if one expects negative consequences or implications. Thus, this behavioral theory considers the influence of others and the influence of situations on an individual's behavior. The theory also begins to touch on another aspect that influences behavior: how one perceives others and situations.

**Cognitive Theories**

One of the most accepted theories of depression among mental health service professionals is that of cognitive theory, credited mostly to Aaron Beck (1976). Cognitive theory focuses on thinking, beliefs, interpretations, and images and how those forces may produce maladaptive behavior. Specifically, Beck (1976) considers thoughts as units known as schemes or schema. An example of a scheme is "my parents care about me." Some thoughts are automatic thoughts or messages given to oneself that precede an experience or trigger an effect. Automatic thoughts influence subsequent emotions and behaviors. Thus, a depressed person may have automatic thoughts of "I am worthless" and subsequent emotions and behaviors are based on that thought.
Other automatic thoughts may include appraisal, in which a judgment is made about the nature of an event and its meaning, or attribution, which is a causal explanation of an event. Automatic thoughts can become so distorted that they result in dysfunctional responses (Sands, 1991). For example, people who suffer from depression tend to blame themselves for their troubles regardless of whether they are responsible or not. In short, depressed people make cognitive errors to support negative pictures of themselves, their experiences, and the outlook for the future. They generalize from a single experience to prospects in the distant future.

In a similar way, Rational Emotive Therapy [RET], developed by Albert Ellis (1979), also suggests that depression arises out of thoughts. RET postulates that irrational beliefs, aroused by activating events, are responsible for the development of neurotic symptoms or dysfunctional behaviors (Sands, 1991). In other words, Ellis found that depressed people make several cognitive errors to support negative pictures of themselves, their experiences or their futures. A depressed person may believe that no one likes him/her in order to support the belief that he/she is worthless. Thus, depressed individuals use inappropriate schemas based on faulty assumptions to interpret life events. Furthermore, Lawrence Kohlberg (1966) proposed that cognitions are based on sex-
typing. Kohlberg suggested that children actively construct
cognitive representations of the world initially in terms of
gender (gender schema) (Nolen-Hoeksema, 1990). This
proposal is much like the behavioral theory discussed
earlier in which gender-appropriate behavior is rewarded.

All in all, cognitive theories postulate that moods
are created by thoughts, and depression arises from negative
thoughts and "twisted" thinking (Nairne & Smith, 1984). The
theories seem to suggest that a person is depressed because
that person makes things worse than they really are. Al-
Issa (1980) notes that "Beck assumes that it is the
distorted thought of persons, rather than their life
situations, that is responsible for depression" (p. 121).
Furthermore, it is suggested that a depressed person may
simply lack positive thinking; therefore, personal
inadequacy is the reason why a person becomes depressed.
Likewise, labeling thoughts as being distorted brings up the
question of who is labeling the thoughts as distorted. When
should a person not trust his/her thinking or perceptions?

This theory of the development of irrational thoughts
does not take into account how distorted rationality may be
in a sexist, racist, agist, poverty stricken world. As a
result, the theory may inadvertently reinforce an
invalidation of feelings. In sum, cognitive theories seek
the cause of depression within the individual, rather than
in the outside environment. It ignores the life situation
of the individual and the possibility that her feelings of worthlessness and inadequacy may be derived from her position in society rather than her imagination.

**Biomedical Theories**

An organic perspective on mental illness has its roots in the writings of Greek philosophers (Sands, 1991). Although Freud always believed that psychiatric disorders were biologically based, later scientists have continued to explore the issue. Today, the biomedical model maintains this organic perspective and now dominates the field of mental health after alternating with an environmental view for several years. This model places the cause of mental illness within the individual who is viewed as having an organic, biochemical or genetic disease. The domination of the biomedical model is due to increased evidence that certain mental health disorders have a genetic or structural basis. The evidence is supported by studies of families, medical discoveries, and even brain imaging (Sands, 1991). Furthermore, the development of psychopharmacotherapy (medications for depression and other mental illnesses) has also increased interest in a biomedical model.

Some studies have found that depression recurs in families. A study by Weissman, Kidd, & Prusoff (1982) found that first degree relatives of depressed patients were more than twice as likely as the general population to develop
depression. The female relatives of depressed patients had one chance in three of a depressive episode while male relatives had a one in six chance (Weissman, Kidd, & Prusoff, 1982). In explaining sex differences, it is suggested that perhaps the x chromosomes carries a mutant gene, predisposing women to depression as women have two x chromosomes (Winokur & Tanna, 1969). On the other hand, perhaps the familial linkage is due to family interaction patterns and learned coping skills.

Although findings such as this one may be encouraging, genetic factors do not show a one hundred percent relationship suggesting that other factors, such as environmental ones, are also involved (Sands, 1991). For this reason, adoption studies have attempted to determine the differential roles of genetics and environment (Rainer, 1985). Unfortunately, the biggest flaw to these studies is the lack of random assignment to environmental conditions. Lowe and Hubbard (1983) note that "in comparing two groups that differ genetically, it is impossible to distinguish the genetic and environmental origins of any behavioral differences between them as long as their environments differ in any way" (p. 95). Thus, genes and environments do not simply add up to produce a whole as the interaction is extremely complex (Bleier, 1984).

Another method that has been tried to determine the influence of genetic factors on depression is the use of
molecular genetic studies. Some studies propose to identify abnormal proteins and genetic markers although those individuals with a genetic marker do not necessarily develop the particular illness (Kaplan & Sadock, 1988). Unfortunately, genetic potential and vulnerability for mental illness are vague qualities that are difficult to trace to genes. Consequently, research on the neurophysiology of the brain has increased and has sought to determine neurophysiological aspects of mental disorders through the use of positron emission tomography [PET] scans (Andreasen, 1984). Although some evidence of structural abnormalities (lesions) has been found among those suffering from schizophrenia, findings about depression are inconclusive.

Another area of biomedical research considers the relationship between hormones and depression. It appears that females are prone to depression during times when their bodies experience significant hormonal changes, specifically the premenstrual period, the first few days after giving birth (postpartum), and during puberty when gonadal hormones emerge. One theory centers on the belief that women's depression corresponds to phases of the menstrual cycle, specifically with hormonal changes (Nolen-Hoeksema, 1990). For instance, premenstrual depression is linked with the hormones of estrogen and progesterone levels. Nevertheless, there has been great debate over the evidence for
premenstrual depression. For example, very few women show depressive symptoms only during the menstrual cycle (Nolen-Hoeksema, 1990).

Moreover, some studies have been hopelessly flawed. One study asked women to retrospectively rate the severity of symptoms experienced during different phases of the menstrual cycle (Halbreich, Endicott, & Nee, 1983). By noting symptoms retrospectively, the respondents may have been biased about what they had expected to have experienced at different periods of the cycle. Another study of premenstrual syndrome was also flawed. The study had women complete a self-report inventory and then report where they were in their cycle (Hamilton, Gallant, & Lloyd, 1989). There was a substantial minority of women who showed at least moderate levels of depressive symptoms during the premenstrual phase of their cycle; however, this study assumed that women did not know where they were in their cycle.

The bottom line appears to be that studies of the menstrual cycle are extremely difficult and complex. Ascertaining the effect of psychosocial factors, particularly beliefs and expectations of menstruation, is as important as establishing effects of the cycle itself. Perhaps women are socialized to expect negative moods during the cycle. Al-Issa (1980) has suggested that society has a negative attitude toward women and menstruation.
Menstruation has always been "taboo" in Western societies and young girls are taught to be ashamed of it. Another possibility is that the cycle may simply exacerbate an existing depressive condition (Al-Issa, 1980; Nolen-Hoeksema, 1990). In addition, simply asking women questions about their menstrual patterns and emotions suggests to women that this is, in fact, the cause of their depression.

Pregnancy has also been thought to be associated with depression. Hamilton et al. (1989) pointed out, however, that pregnancy is associated with a low incidence of psychiatric disorders. Moreover, mood changes occurring in pregnancy most often occurred in women who were predisposed to affective disorders. The relative lack of psychiatric disorders during pregnancy, despite elevated levels of steroid hormones, contrasts with the changes in symptoms that sometimes occur with cyclic hormonal elevations (menstruation). In other words, hormonal elevations during pregnancy are not associated with symptoms of psychiatric disorders although hormonal elevations during menstruation may be associated with psychiatric disorders.

Thus, it may be that depression associated with pregnancy occurs because of the social context surrounding the pregnancy. Negative or conflictual attitudes and feelings about being pregnant may exacerbate symptoms for women with a history of depression. Simplistic biological explanations correlated with reproductive events are
inadequate to explain depression in women. Consequently, researchers should not limit their explanations to the physiological aspects of childbirth, but rather examine the full context in which pregnancies occur, including a woman’s health history, attitudes toward being pregnant, and life stressors.

In a similar way, postpartum depression, the period up to one year after childbirth, has long been considered a time of high risk for women to develop depression (Nolen-Hoeksema, 1990). It is estimated that postpartum psychosis occurs one or two times per 1,000 women (Cutrona, 1982). Nevertheless, there is no difference in symptoms between postpartum psychoses and other psychoses and no difference in the rate of occurrence (Nolen-Hoeksema, 1990). In a similar way, nonpsychotic postpartum depression includes symptoms of sadness, apathy, tiredness while "postpartum blues" has symptoms of unhappiness, anxiety, irritability and emotional lability, suggesting that there is little difference between the two diagnoses (Nolen-Hoeksema, 1990).

Likewise, depression inventories include many of the normal psychological changes of pregnancy and the postpartum period. For example, fatigue, appetite change, loss of sexual interest, aches and pains and other somatic symptoms or common physical problems are often part of these inventories. Stress explanations of postpartum depression appear more plausible (Nolen-Hoeksema, 1990). It is
generally accepted that stressful life events enhance the likelihood of depression. For women undergoing chronic stressors (i.e., financial strain, bereavement, illness, inadequate child care resources, or a poor marital relationship), the recent birth of a child may simply add additional stress, increasing the possibility for postpartum depression (Cutrona, 1982).

The relationship to depression of other aspects of women’s biology such as infertility, abortion, and menopause have not been fully studied (McGrath et al., 1990). Research on the relation of infertility to depression "has included clinical impressions and numerous anecdotal reports that have limited usefulness . . ." (McGrath et al., 1990, p. 11). Likewise, research has shown little association between depression and menopause. In a longitudinal study using a community sample, researchers found that for most women, menopause was not associated with either physical or mental health problems (McKinlay, McKinlay, & Brambilla, 1987). Furthermore, these researchers found that most of the variance in the health status of menopausal women could be explained by previous health status and help-seeking behavior. Similarly, research on abortion and depression suggests that although abortion itself does not appear to be a significant risk factor for depression, psychological response varies depending on age, view of pregnancy, and social support (McGrath et al., 1990). In short,
"Reproductive related events . . . are unique experiences for women and have been hypothesized to be related to women’s depression, although they alone do not explain the overall gender difference in depression rates" (Hamilton, 1984, p. 12).

Research into specific hormones and their relationship to sex-specific behaviors and illnesses has also yielded inconclusive results. One reason for the inconclusive results is the difficulty in isolating the effects of estrogens, progestins, and androgens since females and males produce all three of these groups of hormones. In general, males produce more androgens than females and females more estrogens and progestins than males, although the levels in any individual fluctuate daily under different physiological circumstances (Bleier, 1984). In addition, these physiological ranges overlap. Furthermore, many different forms of estrogens, progestins, and androgens exist in many circulating metabolic forms, each with unique physiological effects with constant conversion forms (Bleier, 1984). For example, in various body tissues of both sexes, cholesterol is normally metabolized to progesterone, which is then metabolized to testosterone (the major androgen), which is finally metabolized to estradiol (the major estrogen).

Thus, on theoretical grounds alone, the effects produced by a particular hormone may not be due to the actions of that hormone but to one of its metabolically
converted forms. Simply put, hormones are not sex-specific in affecting behaviors. Different metabolic forms may have different behavioral effects (Bleier, 1984). Lastly, Bleier (1984) and Carob (1987) note that genetic and hormonal components of depression are not sufficient in themselves to explain the large differentials in the rate of depression among men and women.

The biomedical model does not take into account the complexity of interactions among individuals nor between individuals and their environment. Likewise, this model presents a linear-causal approach that does not consider the many facets of an individual's life. It is also important to remember in biological research that association is not necessarily cause. When women who take estrogen show relief from PMS, we cannot conclude that deficiencies in estrogen cause premenstrual depression just as we cannot conclude that headaches are caused by a deficiency in aspirin just because aspirin relieves headaches (Nolen-Hoeksema, 1990). Nevertheless, psychopharmacological findings have shown that "drugs" reduce disturbing symptoms, providing relief for numerous psychiatric conditions. Tricyclics are most often used to treat endogenous (biologically based) depression. Still in all, medication treats symptoms, not necessarily causes; drugs do not eliminate the psychosocial problems of individuals, their feelings, or their stresses. In addition, although there is good evidence that
antidepressants reduce depressive symptoms, there is concern that women may be overmedicated to encourage them to adjust to intolerable situations which might require real social and political change (Weissman, 1978). Lastly, there can be many side effects of these drugs, including sexual dysfunction, diarrhea, and dry mouth.

**Social Theories**

Social theories suggest that psychiatric or physical disorder is the result of living in a particular form of domestic, economic, and political society (Brown & Harris, 1978). Social theories should not be confused with epidemiological studies in which social factors that lead to increased risk of contact with a physical agent are studied. Rather, social theories have looked at everything from social roles to social oppression. For example, one social theory suggests that women's inferior social status and lack of power in society contribute to their vulnerability to depression, suggesting that depression comes from being undervalued by society (Nolen-Hoeksema, 1990). Moreover, real social inequities and general discrimination against women make it difficult for women to achieve; lack of achievement leaves some women feeling helpless and reinforces "learned helplessness" (Weissman, 1978). Thus, socialization may be the source of depression.
Socialization based on gender reinforces learned helplessness by teaching girls to expect little control over the events at work, at home, and in relationships. Girls are trained early to believe that part of being female requires helpless, passive, dependent, and non-assertive behavior (Weissman, 1978). In that same way, Al-Issa (1980) suggests that symptoms of depression are similar to what are traditionally considered female characteristics: dependency, helplessness, hopelessness, passivity, and lack of self-confidence. Furthermore, girls are socialized to chose from a limited set of occupations, denying them access to the full range of opportunities open to them. Thus, early on girls may feel unwanted and unnurtured (Nairne & Smith, 1984).

As adults, many women receive a similar, constant message that "no matter what they do, they will never be considered as competent as men and will never have complete control over important areas of their lives" (Nolen-Hoeksema, 1990 p. 78). To add to their sense of helplessness, women are socialized not to express their needs or express anger (Bromberger & Costello, 1992; Richardson, 1988). Given these considerations, the personalities of women may be based on socialization and its subsequent manifestations. Nolen-Hoeksema (1990) writes:

A number of studies have shown that females tend to have a lower sense of their own competence, to interpret events more negatively, to evaluate themselves more harshly, to set lower goals for
themselves, and to rely on more external feedback in making judgments about themselves than do males. Such negative thinking styles have been associated with problems in motivation, achievement, and self-esteem, as well as with a tendency toward to depression. (p. 19-20)

These maladaptive self-concepts may stem from the messages that women receive from society. Furthermore, women simply leave most of their self-esteem dependent on the evaluations of others, thereby opening themselves up to social criticisms when they do not follow gender norms.

Yet another category of social theory is that of role theory. This theory is based on the number and type of roles that an individual plays. Many studies have been conducted that associate women's depression with their number or type of social roles (Aneshensel et al., 1981; Kandel et al., 1985; Newmann, 1987; Thoits, 1986). One study suggests that an absence of multiple sources of gratification may predispose women to depression (Kandel, Davis, & Ravis, 1985). For example, if a woman only finds gratification from being a full-time homemaker, when that role is no longer fulfilling, where does she turn for gratification? It should also be noted that the homemaker role is not highly valued by society. Many authors, such as Betty Friedan and Adrienne Rich, and many researchers have described the frustration, boredom, hard work, isolation, and sense of valuelessness of being a full-time homemaker (Gove & Tudor, 1973). Subsequently, it is suggested that multiple roles, which may include marital, occupational, and
housework roles, can act as buffers against depression when the primary role is not gratifying (Morgan, Affleck, & Riggs, 1986). Thus, those with fewer roles, namely single, unemployed, women with no children, tend to have higher levels of depression (Kandel, Davis, & Ravis, 1985).

Thoits (1986) looked at multiple identities (roles) and symptoms of distress, and although this researcher looked at distress but not depression, she makes a good point about the "fundamental non-comparability" of role situations. The author notes that not only do women generally have fewer roles, but women have different sets of roles, such that female, single heads of households who are unemployed could not be compared to male, single heads of households who are unemployed because there are so few men who fit that description. In contrast, others suggest "role overload" (having several roles) can lead to depression (Gove & Tudor, 1973). Likewise, conflicting sets of expectations for particular roles may create depression. For example, women who work outside of the home may need to be assertive without appearing selfish in balancing their roles of working woman and mother. Failure to strike such a balance may lead to conflict, stress, and depression.

Still other researchers have found that the quality of roles and level of satisfaction with various roles is the key to determining vulnerability to depression, not the role itself or the number of roles (Baruch & Barnett, 1986). For
instance, Aneshensel, Frerichs, and Clark (1981) found that both employed women and homemakers had equal levels of depression and both groups were more depressed than employed men. Morgan, Affleck, and Riggs (1986) suggest that roles may be differentially associated with depression, given their level of importance, salience, and centrality. For example, there may be less stress in family roles than work and housework roles, but when stress does occur within the context of a family role, more severe consequences, such as depression, erupt. As noted above, these researchers suggest that participation in multiple roles seems to modify the impact of depression if another role is present to buffer the negative effects of disruption or conflict in one role. However, their data indicate that particular roles interact in specific ways. For example, work has a buffering effect on marital stress, but parenthood exacerbates depression from occupational stress. Similarly, depression appears to affect family roles more than the occupational role (Al-Issa, 1980). In general, it appears that more research in this area is needed to sort out they ways in which women relate to various roles, individually and in combination.

It should also be noted that most of these studies often fail to take into account the multiple daily stresses that many women experience from their environment--inadequate housing, dangerous neighborhoods, burdensome
responsibilities, financial problems—all of which can be more potent stressors than any single acute stressor. These stressors cannot necessarily be alleviated through more or better social roles (Belle, 1990). Social roles may differentially expose the sexes to factors associated with depression. Newmann (1986) first concluded that there was little evidence to support the hypothesis that men and women differ in patterns of vulnerability to depression from stressful life circumstances. Instead, Newmann (1986) suggested that woman may be more at risk for exposure to hardships stemming from the absence of a spouse, social isolation, financial difficulties and chronic health problems. The author found that when exposed to similar hardships, the impact was the same for men and women.

Newmann (1987) later concluded that women may be exposed to more interpersonal stresses. She suggested that women suffer from the "emotional cost of caring" for loved ones and that this extra burden of caring may lead to depression. Likewise, there is some thought that women are not more vulnerable to the effects of undesirable life events but rather, "take on" the stress of others. Women may tend to take on these extra stresses due to their greater emotional involvement in the lives of those around them. Kessler and McLeod (1984) find that women are more likely to be sought out as supporters during times of crisis. For women already overloaded with their own
problems, these extra problems may create a greater sense of depression. This greater "range of caring" thus exposes women to a greater risk of depression.

As a corollary to this finding, McGrath et al. (1990) notes that in demanding training environments, such as medical or graduate schools, social ties may be detrimental for women because they compete with their academic and occupational agendas. It may be that involvement in social relationships may be less protective for women as problems and strains in these relationships increase a risk for depression. In short, women's role obligation to support and nurture others can often strain women.

Further evidence suggests that women's orientation to relationships may be a factor in depression. Jack (1991) finds that self-esteem for women is related to the quality of attachments and relationships such that women may find it easier to handle stress when there is a significant attachment. In addition, women may feel guilt, shame, and depression as the result of a failure to maintain intimate ties. Brown and Harris (1978) found that women who lacked an intimate or confiding relationship with a boyfriend or husband and who experienced a stressful life event had a 41 percent chance of a depressive episode within a few weeks following the episode. When the factors of a confiding relationship and a stressful life event are considered separately, women were about six times more likely to
experience a depressive episode after a stressful life event if they had no intimate relationship. Likewise, women were four to five times as likely to become depressed when no stressful life event occurred but there was also no intimate relationship in their lives (Brown & Harris, 1978). In short, the effect of a confiding relationship and a stressful life event was much greater than the effect of either factor separately.

In recent years, social stress and coping theories have increasingly provided a broad conceptual framework to examine relationships between social support, stressful life events or circumstances, and affective disorders such as depression. Significant life changes or events have been singled out as sources of stress, especially those that involve loss of some kind. Depression has long been known to be a reaction to loss, in particular loss due to the death of a relative or friend. However, there are many types of loss besides death. Loss generally accompanies disability and illness, the end of important relationships, or even the loss of employment. Women may experience higher rates of depression because they are exposed to loss more often or are more vulnerable to the hardships resulting from loss (Newmann, 1986; 1987).

Evidence indicates that stressful life events leading to depression encompass a broad range of events including a move to another city, the birth of a child, or getting a
promotion or being passed over for a promotion while in an unfulfilling job. Generally, depressed individuals report more stressful life events in the six months prior to being diagnosed with depression than the general public (Brown & Harris, 1989). On the other hand, depression can create emotional, cognitive, and social changes in people and their lives that may bring about stressful situations, such as losing a job (Bromberger & Costello, 1992). Nevertheless, many events are simply out of one's control, especially for women who socially, historically, and politically have had little control over their lives.

Lastly, one social theory focuses on the blatant and subtle ways women are discriminated against and victimized in society. Victimization, which may include childhood sexual assault, battering, rape, and sexual harassment, may lead to depression. Victimization in interpersonal relationships is a particularly significant risk factor in the development of depressive symptomatology in women (Wirtz & Harrell, 1987). More and more research is being done to support this theory; however, there are problems in diagnosing women with depression versus diagnosing women with post-traumatic stress disorder given the circumstances of this risk factor. Kilpatrick, Resick, and Veronen (1981) did find that only 20 to 25 percent of victims were free of depressive symptoms one year following a sexual assault.
Demographic Variables and Epidemiological Trends

Demographic variables may also be associated with depression (Bromberger & Costello, 1992). Several researchers have looked at social class, education, and income as contributing factors, but these studies have resulted in inconsistent findings (Belle, 1990; Brown et al., 1990; Brown & Harris, 1978). Nevertheless, some generalities have been formulated. For example, separated and divorced people have the highest rates of depression, although the relationship is more complex when sex, marital status, and marital satisfaction are considered (Bromberger & Costello, 1992). Some data suggest that rates of depression are lowest in men and women who are happily married and highest in married women in unhappy marriages (Weissman, 1987). The association between marital problems and depression may be one of the most consistent findings in the clinical literature though the nature of the relationship is not clear. More specifically, it is not clear whether a depressed spouse creates marital problems or marital problems lead to depression (Bromberger & Costello, 1992). Al-Issa (1980) likewise notes that several studies link depression with marital status. The author summarizes that women were more depressed when married, divorced or separated, but men who were single or widowed were more likely to be depressed.
Further, younger people are very likely to develop depression (Sherer, 1985). Nolen-Hoeksema (1990) writes that her review of the literature suggests that the highest rate of depressive symptoms is among those individuals who are between 18 and 24 years of age. Another study making cohort comparisons found that individuals born after 1936 have an earlier age of onset and higher rates of major depression than those born before 1937 (Bromberger & Costello, 1992). Generally as previously noted, women have higher rates of depression than men; however, Hammen and Padesky (1977) found no sex differences among college students. Nolen-Hoeksema (1990) suggests that only women with good mental health go on to college and those who suffer from depression do not. Similarly, Radloff (1975) found that the better educated the homemaker, the less depressed she tended to be. It may be that the education helps the homemaker to feel more hopeful and less entrapped or better equipped to find ways to occupy her mind. Nevertheless, depression affects women in their most productive years with impairments most marked in work and intimate relationships (Weissman, 1978).

High levels of depression are also commonly found among those with economic problems, and seventy-five percent of the U.S. population living under the poverty line are women and children (Bromberger & Costello, 1992). In addition, people with low socioeconomic status experience more losses
than those of a high status, and it has already been noted that loss is associated with depression (Warheit, 1979). Lastly, women with young children may also have high rates of depression attributed to the fact that their levels of stress increase while their social involvement becomes restricted (Fisher, 1982).

Epidemiological surveys consider the distribution of a disorder within a definite population and relate it to factors such as age, social class, gender (Brown & Harris, 1978). One epidemiological trend is that more recent generations have higher rates of depression (Bromberger & Costello, 1992). Seligman (1988) argues that the depression level of this cohort is the result of a growing obsession with the self; the needs of others, obligations to society or God are secondary to self-exploration. As a result, the person who becomes depressed has no one to turn to.

**Gender Theories**

There may be no true gender differences in the rate of depression, but rather, only gender differences in the expression of depression. Nolen-Hoeksema (1990) suggests that men are unwilling to show the classic symptoms of depression because these symptoms are considered unmanly. Males may learn that it is not socially acceptable or tolerated to express the usual symptoms of depression (Al-Issa, 1980). In fact, men may deny their depressive
symptoms and instead, manifest their depression through other maladaptive behaviors. The kinds of depressive symptoms often do differ between men and women. Men may act out when they feel depressed, while women become sad, passive, and cry, symptoms commonly included in questionnaires on depression (Sands, 1991).

It has been suggested that the "male equivalent" of depression is alcoholism as some studies show twice as many men suffer from alcoholism than women (Williams & Spitzer, 1983). The authors suggest this possibility because both of the disorders of depression and alcoholism may be genetically linked based on family and socialized gender patterns of expressing depression. In addition, depression often follows alcoholism further suggesting that two different maladaptive responses to similarly difficult circumstances are possibly based on socialization and learning. Thus, women may express their depression and seek treatment whereas men attempt to relieve depression through drinking and avoid treatment for the depression. It may also be that women are underdiagnosed with alcoholism.

On the other hand, men have been known to suffer longer depressions and physical illness after the end of a relationship (Stroebe & Stroebe, 1983). In addition, rates of depression actually rise in older men as they retire and no longer have work to distract them (Stroebe & Stroebe, 1983). There is also thought to be a marked difference
between men and women in the utilization of mental health services. Women are more likely to seek admission to inpatient facilities in nonfederal general hospitals and private mental hospitals as well as outpatient facilities; men predominate in admission to state and county mental hospitals and VA hospitals (Russo, 1990). Nevertheless, Nolen-Hoeksema (1990) believes that women are not more willing to seek psychotherapy. The author notes that Amenson and Lewinsohn (1981) found men and women equally likely to seek psychiatric help.

**Literature Review Conclusions**

Recent research findings are as varied as the theories that drive them. Few conclusions can be made as to the definitive factors that are associated with depression. In an attempt to make some conclusions and suggestions, the American Psychological Association’s National Task Force on Women and Depression studied an extensive amount of literature on the subject (McGrath et al., 1990). They suggest the need to take a biopsychosocial perspective of depression across the life cycle (McGrath et al., 1990). Six areas in particular seem to merit attention: reproductive events, personality and other psychological factors, family roles and intimate relationships, work roles, victimization, and poverty. The task force calls for a more careful diagnosis of depression that includes several
of the factors discussed above, particularly noting a reproductive history (McGrath et al., 1990).

Certainly, a more holistic understanding of women and depression is needed. Social work practice has made use of a person in environment perspective that considers not only the individual or the environment, but the interaction between the two. Based on this literature review and the suggestions made by the task force, I have chosen to use a feminist theoretical/ideological framework in the context of social work practice to guide this study in depression and will go into detail about this framework in the next chapter.
CHAPTER III
THEORETICAL FRAMEWORK

The process of objectification and abstraction that are required to turn social work into a science have violated social work's philosophical belief in the uniqueness of individuals and have devalued what social work practitioners do. (Gorman, 1993, p. 247)

Selection of Theoretical Framework

In considering the previous theories of depression, I believe that no single theory provides a complete, holistic view of women and their depression but instead, is focused on only one particular aspect of depression. Given the complexity of how depression manifests itself, I feel that a theory needs to take into consideration the complexity of women and their lives. The perspective that most adequately incorporates most of the previous research information is feminist theory. Feminist theory provides, I think, the best single theory in explaining women's lives and it also supports the practice, ethics, and many incorporated theories of social work.

To assist in explaining my conclusion, I will discuss feminist theory and ideology, social work theory and practice, their similarities and how they relate to women
and depression. I should point out that the terms theory, ideology, and perspective are used rather interchangeably in this work. Definitions of these terms can be debated but that is beyond the scope of this chapter. My purpose in this chapter is to convey the relevant points or themes in feminist theory and ideology and in social work theory and practice as these themes have influenced the perspective taken in this research.

Feminist Theory and Ideology

Feminist theory is "ever tentative, never absolute, and always becoming" (Bricker-Jenkins & Hooyman, 1986). There are, however, some enduring feminist themes. These themes are interrelated and thereby constitute a feminist ideology (Bricker-Jenkins & Hooyman, 1986). First, the theme of patriarchy is part of the feminist ideology. Patriarchy is the institutionalized system of male domination and privilege; it is the mechanism that ensures women's subordination. Patriarchy carries an authoritative set of assumptions, beliefs, and theories to support it. The problem with patriarchy is that it has controlled history, distorted women's experiences and limited women's potential. The second theme is that of empowerment. Feminist theory reconceptualizes power to be of a collective nature, not hierarchical; it is the type of power that is limitless. Process is the third theme within the feminist ideology in
that process is the product. In other words, the process is just as valid and important as the product, and process can be the end in itself. Process is of the utmost importance as it includes the method and the vision of feminist ideology.

The fourth and probably best known theme is that the personal is political. This theme suggests that we change our world by changing ourselves. Within feminist ideology, personal problems have a historical, material, and cultural basis, and thus, personal growth is gained through political action. Unity versus diversity is the fifth theme suggesting the need for sisterhood and the respect for differences among women. Validation of the nonrational, the sixth theme, notes that the patriarchal system controls the process of who asks the questions and who defines the problems, thereby determining what is and is not important. Patriarchal systems objectify social problems as facts when those problems may well be subjective and value oriented. Lastly, consciousness raising and praxis is a major theme. This theme suggests that women need to personally and collectively confront the reality of their conditions by examining their personal and collective experience and putting that into daily personal and political behavior (Bricker-Jenkins & Hooyman, 1986).

One other aspect related to these enduring themes is the notion that feminist writers do not deny their personal
histories or how they come to know what they know (Gorman, 1993; Lather, 1986; Lather, 1991). In other words, every woman's personal life history has shaped who she is, and the events in her life have shaped her beliefs. I too believe that my personal life events have shaped my beliefs and particularly my view of how women may become depressed. Some may criticize that personal life events and beliefs have no place in research as research should not be biased and subjective. I submit that all researchers are subjective and research projects often relate to the researcher's personal life history and beliefs. Most researchers simply never openly state their biases and subjectivity. The projects we choose to pursue, what we choose to see and how we explain those phenomena are based in our own subjectiveness. Harding (1991) states that to be objective one has to be up front about one's subjectivity.

Thus, if my personal life history and beliefs most closely parallel feminist ideology, it is natural that intuitively, subjectively, I would select this particular theory/ideology as a framework for my research. Certainly, my selection of this topic, the framework I have chose, and the conclusions reached all have and will reflect my subjectivity. My subjectivity reflects my social work practice experience with women who suffer from depression. I believe that not enough credence is given to how the social situation of women plays a role in depression. It
has been my experience that women who suffer from depression are given medication to alleviate their symptoms, but little time is spent trying to understand what their daily life is like. Both professionals and patients often minimalize the very real and oppressive environments in which women live. Consequently, little time is spent assisting and empowering women to deal with their difficult situations.

**Social Work Theory and Practice**

Much like feminist theory, there is no one social work theory but rather, enduring themes (Hepworth & Larsen, 1986). For example, central to both feminist and social work theories is praxis, or theory and practice. Social work is based in practice and social work’s themes stem from the many settings and populations in which social workers practice. Thus, social work centers on models of practice or therapies including cognitive therapy, behavior modification, role theory, and existential theories.

The many models of practice do suggest core elements for social work practice: the purpose and objectives of the profession; values/ethics/philosophy of practice; knowledge base; and methods and process employed. Generally, the overall purpose of social work is to promote and restore mutually beneficial interaction between individuals and community. The objectives of social work include helping people enlarge their competence, obtaining resources for
clients, making organizations receptive to people, and assisting with interactions among people and their environment (Hepworth & Larsen, 1986). The values/ethics/philosophy of social work are more difficult to define. Nevertheless, Hepworth and Larsen (1986) suggest some key points that epitomize social work values/ethics/philosophy. One point is that people should have access to resources. Other points include the notions that every person is unique and has inherent worth, people have a right to freedom so long as it does not infringe on others, and the realization that values rest with the mutual responsibility of both the individual and society. The knowledge base of social work consists of human behavior in the social environment, policies, models of practice, and research. Each of these factors are a part of all social work curriculums. Lastly, method and process depend much on the model of practice that is chosen. For example, a method used in most models of practice is establishing trust with a client. Another example is the method of focusing on negative thoughts in the cognitive model of practice.

**Feminist Social Work Theory and Practice**

Social work theory and feminist theory share many similarities. Not only do both theories share similar enduring themes, but both have emerged from women’s lives. Social work emerged from a system of female friendly
visitors and charity organization societies, and feminist theory emerged from the women's movement. The two theories have other points in common. For example, social work practice and feminist ideology share many common values (Wetzel, 1986). These values include facilitating the development and well-being of all human beings through service; recognizing the intrinsic worth and dignity of all human beings; facilitating active participation in society; removing obstacles for self-realization; and preventing and eliminating discrimination.

The similarities of the two theories make it possible to combine them and form a feminist social work practice model. The central beliefs of this model are that patterns of institutionalized sexism create problems for all persons and that distress experienced by women has societal and cultural origins (Bricker-Jenkins & Hooyman, 1986). Feminist social work practice centers on assisting others to gain autonomy and self-determination (Bricker-Jenkins & Hooyman, 1986). Feminist social work practice is defined by approaching all issues presented by social living and social relationships, and by identifying their implications for women. In short, Bricker-Jenkins and Hooyman (1986) note that:

What distinguishes feminist practice is the centrality of its ideology. Although all practice embodies ideologies, few practitioners make their ideologies explicit and consciously examine their performance against their ideologies. For feminist practitioners, ideology is the core of
practice--the measure of all choices to be made--and is consciously used to motivate and evaluate action. (p. 7)

Feminist Theories of Depression

Feminist researchers and scholars have suggested that women's mental illness, especially depression, is linked to their oppressed status in society (Miles, 1988; Nairne & Smith, 1984; Sapiro, 1990). In other words, depression may arise out of women's common daily experiences of oppression through economic, cultural and social influences. These influences or factors have been studied and there is an increasing pool of causal variables. Miles (1988), for example, reports that "the feminist argument is that women become depressed because they have reasons to be so; that their position in society is one of disadvantage vis-a-vis that of men" (p. 10).

Brown and Harris (1978) attempt to confirm that depression is a female condition by noting that women's education, employment, power, prestige, and opportunities compare unfavorably with men. For instance, given the generally low economic status of women, depression may stem from the interaction of a low income in a racist, patriarchal, capitalistic society (Sidel, 1986). Further, Al-Issa (1980) notes that with the increase in the number of educated females, depression may be more likely for women who face low job opportunities. Weissman and Klerman (1977)
suggest that:

Depressions may occur not when things are at their worst, but when there is a possibility of improvement, and a discrepancy between one’s rising aspirations and the likelihood of fulfilling these wishes. The women’s movement, governmental legislation, and efforts to improve education and employment opportunities for women have created higher expectations. Social and economic achievement often have not kept pace with the promises, especially in a decreasing job market and where long-standing discriminatory practices perpetuate unequal opportunities. (p. 62)

As noted previously, mental illness has been found to be at least 2.5 times more visible in the lowest social classes than in the highest (Neugebauer, Dohrenwend, & Dohrenwend, 1980). Women who work find that most jobs available to them tend to be concentrated in occupations with low authority, high responsibility, and few benefits. In fact, ninety percent of all low wage clerical and task jobs are occupied by women (Paltiel, 1988). Those who are able to attend school most often find themselves in such occupations as nursing, teaching, and social work—all high stress, low paying occupations. Although money is not a guarantor of mental health, and poverty does not necessarily lead to mental illness, it is generally conceded that poverty can be both a determinate and a consequence of poor mental health (Paltiel, 1988).

Furthermore, high levels of depressive symptoms have been found to be particularly common among women without confidants with no child-rearing assistance, or who are
unemployed. High levels of depressive symptoms are also found among women experiencing chronic stressful conditions, particularly those reflecting economic problems (Belle, 1982; Belle, 1990; Brown et al., 1975). One reason for these correlations is that poor women experience more frequent, more threatening, and more uncontrollable life events; poor women are more exposed to crime, violence, illness, and death (Belle, 1990; Brown, Bhrolchain, & Harris, 1975). Although rapid, uncontrollable change is one important source of distress, persistent, undesirable conditions that must be endured daily can also be stressful (Belle, 1990). In sum, Belle (1990) suggest that "at a very basic level, it is still not clear whether poverty functions to hasten or precipitate the onset of psychological disorder, to prolong their duration, or to increase the likelihood of relapse following recovery" (p. 387).

In addition, there is the common belief among feminists that mental illness labels tend to hide the essentially social nature of women's problems. For example, postpartum depression could be considered to be the medicalization of unhappiness following childbirth. Furthermore, Miles (1988) suggests that "illness, like deviance, is a social concept, and attaching the name 'illness' to a condition has social consequences" (p. 18). Feminist theory also suggests that more women take psychotropic medications than men "to maintain them [women] in a role which they find difficult or
intolerable without a drug" in order to maintain the status quo (Miles, 1988, pp. 11-12).

**Reason for Framework**

The reason that I chose this framework based in feminism and social work is because it makes sense to me and encompasses my beliefs. All researchers choose a theory that makes sense to them. As Harding (1991) notes, from the perspective of women's lives, scientific rationality frequently appears irrational. I wanted a perspective that made sense not only to me, but to my participants. Too often, I feel, we hear about individuals not taking responsibility for their problems, but we almost never hear of societies taking responsibility for the problems of its people. Depression seems to be a socially constructed problem given who it affects, how, when, and where.

I searched for studies that made use of a feminist perspective and research methodology. I found few that identified their studies in that way, and fewer still that made use of a feminist perspective and research methodology in social work. Those that have used the perspective have not studied depression. This study, then, adds a unique voice to research in the area of depression. One study reviewed is worth looking at in some detail as it helps to illustrate that basing research on feminist theory goes beyond understanding the data in terms of a theoretical
perspective. On the contrary, a feminist theoretical perspective guides the way in which the study is done, which questions are asked, how data are analyzed, and how the research should be used.

**A Similar Study and Critique**

In a study conducted by Miles (1988), the researcher used a "feminist sociological/social causation" perspective. The author stated that the intention of her research was to take information from participants seriously and to explore their assessments of their situations, a central point of feminism. Nevertheless, the author felt it necessary to have a small comparison base of male participants, perhaps suggesting some ambivalence about women's assessments. The research team spoke with 65 women and 20 men about depression. Thus, the study was already set up to be comparative even though the focus was on women and depression. It was as if a male perspective was needed to establish the standard or the norm, and women were compared against that standard. This method did not seem to be in step with a feminist perspective. The study was very large and based on 200 interviews which focused on the experiences of female "psychiatric patients." The author’s reason for focusing on women was that more women than men are diagnosed with depression. Miles also recognized that women, in general, are more willing to discuss their personal lives,
particularly with female researchers who can more easily establish rapport with those of their own gender.

All the interviewees were married and living with their spouses. Participants ranged in age from 20-55. It was unfortunate that the researcher did not focus on a smaller age span since this research decision implies that no differences exist among women 20 to 55 years old, and that age is not a factor in depression. Further, all participants in this study had been referred to a psychiatrist for the first time, diagnosed as suffering from a neurotic disorder, and recommended for outpatient therapy. As noted previously, this method decision has several flaws when it comes to maintaining a feminist perspective. To begin with, most psychiatrists are male, and there may be a tendency to diagnose women with depression more often than men who suffer from depression. In addition, participants were labeled by someone in a position of power, a point not in keeping with feminist theory.

Although the research had an 85 percent response rate, the letter requesting participation was sent via the psychiatrists, thereby suggesting that some participants may have felt obligated to talk to the researcher. The study aimed to make the talks as pleasant as possible, informal, with no time restraints. Interviews took place in the participants’ homes. Both decisions demonstrated a feminist perspective in that interviews were done in everyday places,
not in artificial labs with controlled instruments. On the other hand, the researchers felt that to "lend a willing ear" was enough return for taking up people's time. This decision seemed most incredible given the feminist belief that information should be shared and women deserve something in return for sharing their time, openness, and willingness to participate.

Miles (1988) came to some very interesting conclusions in her research. The analysis and conclusions were certainly consistent with a feminist/sociological perspective. Miles noted that in trying to find answers, participants were involved in an agonizing review of their lives and were forced to rethink the relationships and events pre-illness. In general, women thought more about the causes of their depression than men, yet the women summed up their problems with "I can't cope." The author suggested that blaming oneself was consistent with the desire to be in control, whether for good or bad (even accepting blame for crimes, bad marriages, etc.) The author also recognized that the causes of depression needed to make sense to the individual, and the causes that seemed to make the most sense were those socialized to make sense to women.

Furthermore, women who considered that the hardships of their daily lives played a full or partial part to their depression took into account only the most severe circumstances and events as the cause for the depression.
Participants frequently expressed the view that the women were making too much of nothing and should snap out of it and pull themselves together. Almost all of the women found it difficult to think of their depression as an illness. In addition, women tended not to accept the "obvious" choice for a cause of their depression, such as a loss of some kind. Miles (1988) found that housewives were told that they were responsible for the lives and well-being of their families, and they were blamed for both the psychological and physical problems of their children. In particular, Miles (1988) found that psychiatrists appeared to steer women toward domestic explanations, reinforcing their self-perception. The male participants, on the other hand, based their source of depression in work-related problems and physical illness; hardly any of the men explored their own past actions as possible causes.

Finally, the author found a great value in social support among participants, although support often deteriorated as depression continued. Surprisingly, of the 65 married women interviewed, only 24 named their husbands as their main confidants and supporters. Those who named their husbands felt that they had to since there was no one else to turn to. There was a sad irony to this finding in that the only person to turn to for emotional support in a crisis was the one with whom they were in conflict, since most women reported unsatisfactory marriages. The author
suggested that men's failure to appreciate their wives' emotional needs was likely rooted in Western cultural values. In addition, Miles (1988) found that women feared placing too many demands on close friends and relatives in an effort not to become a burden. There seemed to be an assumption that women should be caretakers for others but not seek care for themselves.

The author felt that many of the women were too often prescribed drugs. In addition, doctors appeared to attribute women's problems to childbirth, menopause, childlessness, and other experiences unique to women. Perhaps doctors felt depression was part of being a woman and were therefore less sympathetic to the stress associated with the daily life experiences of women. At any rate, the author seemed to find considerable evidence that the nature and causes of depression for men and women differed. Like Miles' study, a feminist theoretical perspective is used in this study and that perspective informs the methodology used. The discussion of the methodology chosen for this study is to follow.
CHAPTER IV

METHODOLOGY AND PROCEDURES

Possibly the understanding of human life will be as much advanced by the direct study of social phenomena as by the study of numerical symbols abstracted from this phenomena. (Waller, 1934, quoted in Bogden & Biklen, 1992, p. 15)

Paradigms

Paradigms are "a loose collection of logically held together assumptions, concepts, or propositions that orient thinking and research" (Bogden & Biklen, 1992, p. 33). Paradigms can also be a constellation of theories, questions, methods, and procedures which share central values and themes (Maguire, 1987). In short, paradigms function as guides in research (Nielsen, 1990). They dictate the kinds of problems that are important to address, the theories that are acceptable, and the procedures that will solve the problems (Maguire, 1987).

Furthermore, it is assumed that the paradigm influences not only what a researcher sees, but also what he/she chooses not to see. Research, therefore, deals with perceptions, not facts (Patton, 1990). Maguire (1987) notes that "to propose that an objective social reality exists external to human consciousness and creation is to deny that
social reality is humanly and socially constructed" (p. 22). Thus, this study is not searching for truth, but rather a perspective by the participants of their socially constructed reality. It is hoped that the participants' perspective will inform future research by providing new directions toward factors in the etiology of depression that are relevant to those who suffer from depression.

**Qualitative Research**

Naturalistic inquiry is defined, not at the level of method, but at the level of paradigm (Lincoln & Guba, 1985). Thus, qualitative research really does not have theoretical underpinnings; instead, qualitative research is based on paradigms. Bogden and Biklen (1992) note that "qualitative research" is an all encompassing term. This particular research style can also be known as field research, naturalistic inquiry, or ethnography and may refer to everything from symbolic interactionism to phenomenological study to case study. Qualitative research can be traced to the nineteenth century at which time muckraking journalists were investigating the problems that accompanied the urbanization and mass immigration to the cities (Bogden & Biklen, 1992). At the same time, the Chicago School and other groups of sociological researchers began to borrow from the methods of anthropologists. The sociologists contributed to the qualitative research method by studying
mostly new immigrants to this country, city life, and the community. Most took an interactionist approach. The approach is not unlike that taken by early social workers such as Jane Addams and her practice at Hull House.

Qualitative inquiry is an inductive mode of research that is set in a specific socio-historical context, and data may be conveyed through norms, values, or meanings related to human behavior (Mickunas, 1983). While there are various types of qualitative research, all share to some degree the goal of understanding the subjects from their own viewpoint, and this viewpoint may be negotiated with the view of the researchers. There are some other common characteristics of qualitative research: a natural setting is used as the direct source of data; the researcher is the key instrument; descriptive data are utilized; the concern is with process rather than simply outcomes or products; the data are analyzed inductively; and the meaning of the data are derived from capturing perspectives accurately (Mickunas, 1983). The goals of qualitative research include some attempt to develop grounded theory, to create concepts, and to describe situations, people, or cultures.

Again, the goal of qualitative research is not to collect facts, as human behavior is too complex for that, nor is it looking for cause and prediction. Instead, the main goal of qualitative research is to better understand human behavior and experience. Thus, in qualitative
research, the researcher’s primary goal is to add to knowledge, not to pass judgment on the data. The worth of a study is the degree to which it generates theory, description, or understanding. Qualitative data are descriptive data with a purpose of displaying daily events of those under study.

Some question whether qualitative methods are really scientific. After all, measurement has been synonymous with science, but the irony is that scientists in the "hard sciences" do not define science as narrowly as those who emulate them (Bogden & Biklen, 1992). Another question is whether there is a reproducible method that all investigators could or should follow. One answer is that science really depends on being open-minded about evidence and methods and perhaps should not be limited to one particular method. If scientific research requires rigorous and systematic empirical inquiry that is based on data, then qualitative research meets this requirement. In addition, Kirk and Miller (1986) note that:

> Despite the prestige and success of natural science in recent years, application of science as a model for social ‘science’ is not inevitable. Many have argued that social science has an intrinsically different set of goals that call for an altogether separate collection of methods. (p. 13)

All research is done via a researcher’s biases/opinions/prejudices (Bogden & Biklen, 1992). Harding (1986) points out that the questions asked; the data available and
considered relevant; the hypotheses used; and the way in which data are obtained are all open avenues for bias. Therefore, it is nearly impossible for researchers to objectively study others' subjective reality. There are those who believe that qualitative research may become just a collection of subjective, impressionistic essays. In fact, the qualitative researcher spends considerable time laboriously collecting, reviewing, and analyzing the data while also confronting his/her own biases/opinions/prejudices.

Some ways to limit bias in qualitative research do exist. Keeping detailed field notes and reflections on one's own subjectivity are two ways to limit bias. Nevertheless, researchers can never eliminate their own effects on participants or their own bias and subjectivity. Likewise, all research is informed by some theoretical understanding of human and social behavior. Roman and Apple (1990) suggest that the "prior theoretic and political commitments" of the researcher are "informed and transformed by the lived experiences of the group she or he researches" (p. 62). Polkinghorne (1983) perhaps sums up qualitative research methods best when he states that "method does not give truth; it corrects guesses" (p. 249).
Feminist Research Methodology

One type of qualitative research methodology is feminist research methodology. Feminist research is "to put the social construction of gender at the center of one's inquiry" (Lather, 1991). Lather (1991) goes on to suggest that "feminist researchers see gender as a basic organizing principle which profoundly shapes/mediates the concrete conditions of our lives" (p. 71). Thus, the goal of feminist research is "... to correct both the invisibility and distortion of female experience in ways relevant to ending women's unequal social position" (Lather, 1991, p. 71). One way in which to do this is to look for methods of inquiry in which the analysis suggests pattern and meaning to empower women rather than prediction to control behavior (Lather, 1991). Three major themes occur in feminist research methods (Weiler, 1988). First, feminist researchers begin their work from a grounded position in their own subjective oppression. Second, the research is characterized by emphasizing lived experience and the significance of everyday life. Third, feminist research is politically committed to change the position of women and society in general. In short, feminist research methods demonstrate that the process is just as important as the product.

Feminist researchers in social sciences have been attracted to qualitative methods because these methods
enable the interpretations of women to be important. Likewise, feminist research methodology has shaped qualitative research in several ways (Bogden & Biklen, 1992). Feminist methods have influenced the subjects studied such that gender has become the central topic. Feminist research methods have also taken women seriously and brought their concerns to the forefront. Furthermore, feminist research methods have affected the content of research in how informants make sense of the ways gender constructs their worlds. Moreover, feminist research methods have led the way in developing emotion and feelings as topics for research (Bogden & Biklen, 1992). In addition, feminist methodology has affected methodological questions as well the power in the interviewing relationship. Lastly, feminist research methods have moved qualitative research toward greater concern with relationships between researchers and their participants and the political implications of that relationship (Bogden & Biklen, 1992).

Feminist theory and research methodology has a strong relationship to postmodernism in the transformation of science. For example, a shift away from methodological approaches in the social sciences that are designed to find the "truth" of propositions may be considered to be postmodern. These methodological approaches have moved toward a more relativist stance that fosters "multiple
voices and multiple realities" that were marginalized. Consequently, postmodernism in the social sciences does not continue the positivist notion of trying to improve and perfect theory but instead, focuses on expressing underlying assumptions. As a result, the choice of research question becomes less determined by method and more determined by the researcher and the participants.

In this regard, "social work academics and researchers must begin to recognize that social work practitioners do research every day of their work lives" (Gorman, 1993, p. 252). This research is a form of inquiry that is intensely subjective, interpersonal, ideographic, value laced, and interpretive and often takes a narrative form. For these reasons, positivist methods are incompatible with the assumptions in social work regarding the uniqueness of individuals and constructions of meaning. More and more social work research is being based in qualitative methodology. As noted earlier, feminist theory and research methodology appear to be particularly well suited for social work research.

One particular feminist theory that is well suited for social work research is feminist standpoint theory. According to Swigonski (1993), feminist standpoint theory provides the tools to construct social work research that honors the profession's primary practice imperative. Social work research based on standpoint theory honors the
profession’s commitment to the empowerment and social transformation of clients. One’s standpoint emerges from one’s social position, gender, culture, color, ethnicity, class, and sexual orientation, and these factors affect everyday life. Thus, the theory directs researchers to problems within the daily life of groups of people and attempts to understand how the social structure contributes to the problems they face. Standpoint theory encourages researchers to ask new questions as those questions come from different standpoints.

Many differences in the situations of men and women exist such that there are reasons for using feminist research methodology (Harding, 1991). One major reason is that women’s different lives have been devalued and neglected as starting points for scientific research and as generators of evidence for or against knowledge claims. Likewise, women are valuable "strangers" to the social order; women have been excluded from the design and direction of both the social order and the direction of knowledge. Going on, women’s oppression gives them fewer reasons to invest in maintaining or justifying the status quo in comparison to dominant groups and some women’s perspectives are from the "other side" generating less partial and distorted accounts.

Furthermore, most women’s perspectives are from everyday life, not the abstract conceptual world of men.
Most women's perspectives come from mediating ideological dualisms such as nature versus culture or intellectual verses manual work. Lastly, women, especially women researchers, are "outsiders within," a situation that may reveal views of reality obscured by more orthodox approaches. When one works on both sides, there emerges the possibility of seeing the relationship between dominant activities and outside beliefs with inside feelings and intuition. In short, this appears to be the right time in research to use feminist methodology given the conflicts in women's lives today.

Biases in Methodology

Positivistic research methods have produced and perpetuated biases against women (Harding, 1991). In the first place, it is clear that the sciences and their technologies today, as in the past, provide benefits disproportionately to members of the dominant race, classes and gender. Moreover, resources from research are frequently used not just for the benefit of the few, but also for the direct oppression and exploitation of the many. In other words, science has simply provided resources for some people's domination of others. In addition, social desires are frequently defined as technological needs, thereby legitimizing scientific research. Likewise, the technologies used to produce scientific information are not
value-neutral. In short, the sciences generate information that is used to produce technologies and applications that are not morally and politically neutral; there is no such thing as pure science with a focus on application only. Thus, we simply can not absolve scientists and the groups supporting scientific research of responsibility for the consequences of science.

Masculine bias in social inquiry has consistently made women’s lives invisible, distorted, and silenced (Harding, 1991). In societies where power is organized hierarchically, there is little possibility of an impartial, value-neutral perspective. Furthermore, areas of social inquiry have been overlooked because conventional modes of scientific inquiry, such as ignoring emotion as a topic for research. As a result, the focus on public, visible, official roles and definitions of situations ignore the informal and supportive world of women. In addition, generalizations from research to all people may not include women as many women inhabit a different sphere in society (Harding, 1991). In sum, gender has not been taken into account as a factor in research, and in many fields, gender has simply and deliberately been left out or ignored.

Biology and the social sciences have led to what many now conclude are misleading or inadequate understandings of women’s and men’s natures and activities in social life. Harding (1991) asks:
Is it an accident that many of these biological and social theories were created in the nineteenth-century Europe and America during a period of vast change in women's and men's traditional division of labor, during shifts in the meanings and references of heterosexuality, and during the beginnings of agitation for equal education, employment opportunity, and political suffrage for women? (p. 106)

Many theories are historical creations. To change this trend, women's contributions to the sciences could form a more comprehensive picture of human activity. Women's access to data is itself an important source of improved science as women tend to ask different questions, have different perceptions, and interpret data differently. Thus, an important origin of androcentric bias in social science and biology occurs in the context of discovery—in the selection and definition of the problems for inquiry.

Harding (1986) also asks if this methodological preference in the social sciences for emphasizing the simplest kinds of differences rather than the reciprocal, interactive complex relationships express a distorted masculine bias that appears in the natural sciences. It appears that attempts by social science to mimic the purported objectivity of the physical sciences is one area in particular in which feminists claim to find this bias. This bias materializes not only in the limited access men can get to women's worlds or the invisibility of the analysis of that world, but also in the assumptions researchers make. This criticism has led some to suspect
that the focus on quantitative measures, variable analysis, and impersonal and abstract conceptual schemes are a masculine tendency and serves to hide the "gender character" of positivistic science (Harding, 1986).

Masculine bias in research continues to exist because it is thought that to achieve the kind of objectivity and prestige characteristic of physics, "science" must be done in a numerical, dichotomized, quantitative way (Harding, 1991). Fez (1981) finds that masculinized dichotomies are crucial in four ways to the maintenance of the belief that science is objective:

1) Issues about production of knowledge must be kept distant from those studied, lest scientists be forced to take responsibility for goals beyond the pursuit of knowledge for its own sake and lest the public be encouraged to seek more power over the choice of what research is to be funded and who is to perform it.

2) Thinking and feeling must be kept separate lest scientific rationality be forced to respond to how people feel about the probable social consequences of their own or others' successful research on weapons, biomedical projects, and social control.

3) The scientific subject, the scientist, must be kept separate from the scientific object, the participant.
4) Science must be presented as separate from society precisely to obscure its intimate relationships to political power. In addition, the very focus on sex differences in the face of the incredible similarities between the sexes may itself be a reflection of distinctively masculine projects.

In sum, "sexist science is morally and politically wrong because it supports those desires and interests of men that are satisfied only at the expense of women as a group" (Harding, 1986, p. 109). Past methodology procedures are very quantitative, and past quantitative work on depression has been preoccupied with measuring something that is not only ill-defined, but comes from a patriarchal, seemingly nonobjective viewpoint. For example, studies often measure symptoms of depression along with symptoms of anxiety and/or states of well being, making it difficult to determine actual levels and prevalence of depression (Thoits, 1986). Likewise, particular depressive symptoms that are more likely to get a response from women (i.e. feelings of unattractiveness, crying spells) tend to predominate on scales of depression (Ridsdale, 1986; Menaghan, 1990; Newmann, 1987).

New methods can result in new ideas, insights, and results. Most studies on depression in the past have been based on a male perspective, male definitions of mental illness, and quantitative studies. Few other studies look
at women and depression using qualitative methods. Lastly, Strauss & Corbin (1990) note that:

Qualitative methods can be used to uncover and understand what lies behind any phenomenon about which little is yet know. It can be used to gain novel and fresh slants on things about which quite a bit is already known. Also, qualitative methods can give the intricate details of phenomena that are difficult to convey with quantitative methods. (p. 19)

Research Methodology Decisions

The differences between qualitative and quantitative research methods center on objectivity versus subjectivity; researcher distance versus closeness to subject; generalizations versus uniqueness; social control versus self determination; and impartial advice versus solidarity and action (Maguire, 1987). The decision to collect little data from many participants or in-depth, detailed data from a few participants may rest with individual researcher preference, but is also heavily influenced by the chosen research method. Brown and Harris (1978) note that detailed knowledge of the person and the disorder allows the researcher to make sense of the meaning that the symptoms have for that individual. The snag is that the detail makes it difficult to move beyond the individual case. For example, the statistical survey has the reverse problem. In survey work, comparability tends to be maintained at the expense of ignoring the complexity of the individual.
In making research decisions, each researcher needs to ask for whom is this issue a problem? What is the participant’s life like? What does the researcher wish to convey to the reader? What is the researcher’s political agenda? Feminist theorists assert that the purpose of research must benefit the subjects of research (Cook & Fonow, 1990). Likewise, the researcher’s reflexivity is important because researchers need to consider the influence that they have on the design, the implementation, and the conclusions of a study. Bleier (1984) called for scientists to acknowledge their values and beliefs and to identify the influence of those values and beliefs in their projects. After all, scientific knowledge is socially situated and social and cultural values determine everything from the idea to the conclusions.

Design for Study

The research for this study takes an "applied research" form with the purpose of understanding the nature and sources of human and societal problems (Patton, 1990). In terms of design categories set by Patton (1990), this study is closest to ethnomethodology which has as its central question, "how do people make sense of their everyday activities so as to behave in socially acceptable ways?" In selecting breadth or depth, the qualitative, feminist research method shows preference to study selected issues in
depth and detail. The fact that data collection is not constrained by predetermined categories of analysis contributes to the depth and detail of qualitative data.

**Focus**

The focus of this study was on young adult women and depression. Women were selected for this study for the reason that they are more often diagnosed with depression. The illness of depression was chosen as a focus because of the huge numbers of women that are affected by it and my social work practice with women who are depressed. I chose to focus on the everyday lived experiences of this group of women and what in their experiences has led to their depression.

I focused this study on a point in the life cycle as suggested by McGrath, et al. (1990). I selected young adult women, 19-32 years old because young people have been shown to have high rates of depression, and yet, this is a very productive, exploratory time of life for women. Also, most studies tend to lump women 18-44 into one cohort group which I believe is too large. I chose to study single, educated, young adult women without children because these factors have been associated with few depressive symptoms. In this way, I could focus on other less established correlations to depression.
Pilot Testing

No pilots for this study were completed due to the lack of time and funding. I did obtain assistance on methodology, data analysis and research writing from courses on qualitative research taken during the early phases of this study. One course was taken each quarter and the courses consisted of feminist research, qualitative research practicum, and analyzing qualitative data. These courses were really quite vital in assuring that proper and thorough procedures were followed. This additional course work also gave me the chance to solicit feedback and peer support. Some preliminary work was done for this study, such as document analysis and testing questions on peers, but no formal pilot was conducted.

Instrumentation

For this study, the main piece of instrumentation utilized was myself. The only recording medium was that of a microcassette recorder to preserve the interaction of the researcher and the participants. In addition, a personal reflexive journal was kept to record observations about the participants, the researcher’s feelings, and research decisions. A computer with a basic word processing program (WordPerfect 5.1) was used for the transcription of the data. A data analysis software program, HyperPAD, was used to assist in storing, coding, and comparing data.
Site of Study

Multiple sites of the participants' choosing were used. Most participants wished to be interviewed in their homes or mine. Each site was that of a relaxed setting. All sites were in the campus area and included both dorm rooms and student housing. Consequently, most sites were neither opulent nor spacious and not without interruptions from peers or neighbors. Nevertheless, these were thought to be typical living conditions of most educated, single, young women.

Sample

Seven young adult women, ages 19-32, were selected for participating in this study. The sample of participants represented a cross section of race, age, and class. All women were college/graduate educated and all were self-identified as depressed. All participants were strictly volunteers who never married and had no children.

The sampling technique used is best described by Patton (1990) as purposeful sampling with maximum variation. That is, purposefully picking a wide range of variation on dimensions of interest to document variations that emerge as participants adapt to different conditions. This technique identifies important common patterns that cut across variations. This strategy also aims at capturing and
describing the central themes or principal outcomes that cut across a great deal of participant or program variation.

The logic behind this technique is that any common patterns that emerge from great variation are of particular interest and value in capturing the core experiences and shared aspects. It was hoped that a similarity of experiences would cross race and class, while holding gender, age cohort, education, number of children, and marital status constant. In actuality, these varied participants were not deliberately selected. It was simply by chance that a diverse sample was obtained. All eligible participants who inquired about the study were accepted for inclusion except one woman who needed to be referred; this woman thought that the study was a chance to obtain therapy.

This type of sample was selected to yield two kinds of findings: high quality, detailed descriptions of each case (useful for documenting uniqueness) and important shared patterns that cut across cases and emerge out of heterogeneity (Patton, 1990). The findings, therefore, could not be generalized to all women of this age cohort, but they provide information that brings an understanding of the common patterns within this variation. To give some idea of the variation among the participants, the following information is provided on each participant: age, level in school, major, race, and any other significant variable.
Participant #1: 22 years old, Sophomore, Elementary Education major, white.

Participant #2: 31 years old, Doctoral student, Russian Literature major, white, and a recent immigrant.

Participant #3: 23 years old, 5th year Senior, English and Women Studies major, white, Jewish.

Participant #4: 22 years old, 1st year Law student, African-American.

Participant #5: 19 years old, Freshman, pre-social work major, white.

Participant #6: 28 years old, Doctoral student, Art Education major, Asian from India.

Participant #7: 25 year old, Doctoral student, Agriculture/Rural Sociology major, white and raised in Africa.

Additional Data

Observational data and a researcher's reflexive journal were also kept and analyzed to assist in describing the setting, people, and meanings. The observational data and reflexive journal, described by Patton (1990), provide a description of what has been observed, what the observer is feeling, what participants say, and what the observer sees, interprets and reflects. The criterion for inclusion in the final report is whether that observation permits the reader to understand the situation described (Patton, 1990). I made overt observation notes while interviewing participants and shared my notes if requested by participants. Other thoughts, reflections, and reactions were written after the interview.
Data Collection Procedures

In qualitative interviewing, Patton (1990) states that "the quality of the information obtained during an interview is largely dependent on the interviewer" (p. 279). Interviews were chosen as a means of gaining the participants' perspectives on depression as researchers cannot observe everything, most notably past actions, behaviors, and feelings. Thus, in-depth, individual, face to face interviews were conducted. This study used a non-scheduled, general interview guide approach in which a set of issues were outlined. This guide was referred to before interviewing each participant. The issues included biological factors, developmental factors, provoking agents, vulnerability factors, relationships, demographic factors, role factors, violence, images of women, and help seeking behavior. The issues were not in any order and the actual wording of questions was not determined in advance, except for the University's Human Subjects Review Committee who required specific questions (see Appendix F). All issues were not discussed with any one participant. Naturally, some of these issues were encouraged for discussion, but in keeping with an inductive mode, discussion topics were generally raised by the participants.

An unstructured interview guide was used because this method allows for maximum flexibility and for the interviewee to decide what is important to her for
discussion. Lincoln and Guba (1985) confirm that unstructured interviews are the mode of choice when the interviewer "does not know what he or she doesn't know..." (p. 269). There was only one set question: How depressed do you feel you are at this moment? Open ended questions were used to investigate any issues more in-depth. I do not believe that participants were able to give the "party line" as they were interviewed in different settings and did not know each other. I thought that interviewing peers would be more productive and encourage openness; therefore, all interviews were conducted by myself. Collecting all the data alone turned out to be difficult at times, but procedurally, this technique reduced the possibility of data collection differences among participants. Lastly, a collection of general information pamphlets on depression were obtained from area clinics and outpatient facilities to assist in demonstrating what information may have been obtained about depression by the participants prior to the interview.

Process

The qualitative researcher typically arrives in the field with considerable theoretical baggage but very little idea of what will happen next. For this reason, researchers tend to use theory, common sense, and any resources at hand when collecting data (Patton, 1990). In the process of
collecting data, the researcher must be cognizant of the fact that throughout an investigation he/she will make procedural decisions that are totally imbued with assumptions about the nature of the social reality that may or may not be held in common with those persons who are to be investigated (Murphy, 1983).

The process of this project spread out over a year, not including the write up. It began, of course, with the basics of all research, the proposal. Once approved, the proposal was reviewed by the University's Human Subject Review Committee. After this approval, funding was sought via various local, campus sources. Unfortunately, funds could not be obtained for this project. Nevertheless, I went ahead with my original research process plans while simultaneously taking one research related course per quarter to assist in proper procedure. Data collection took place between April 30, 1992 and July 20, 1992. The extent of my involvement in the "field" to be research was actually quite involved as I lived in the field (on campus) and was an acquaintance to some of the participants. In qualitative terms, I was an "insider."

Participants in the study were recruited from the campus area. Several obstacles to recruitment included having a limited area from which to obtain participants and limited funding. Flyers soliciting participants were put up around preapproved sites on campus and were handed out in
preapproved social work courses (see Appendix A). Approval consisted of seeking out the correct "gatekeeper" who needed to be aware of the posting and approve it. Seeking out approval turned out to be a cloudy maze of bureaucratic hierarchy. Lincoln and Guba (1985) note that the process of negotiating consent or "gaining entree" with a gatekeeper can be a difficult, bureaucratic one and in this case, the authors were certainly correct. Nevertheless, once the flyers were posted, the first call from a participant came just six hours later. Approximately 125 flyers were posted in the main student union, the student mental health clinic, the student counseling center, two introductory social work lab courses, the college of social work, two graduate dormitories, and the education building. The women who responded to the flyers had self-identified their depression as I did not rely on definitions of depression nor did I use a standardized measure for depression. As previously noted, definitions of depression and standardized measures of depression may very likely be biased.

Three of the eventual participants were acquaintances as they lived in the same dorm as me; four participants were new to me. Participants made appointments by calling me, and they only gave their first names, subject to demonstrating that they met criteria for the project and were willing to participate. This procedure provided for confidentiality for those who wished to inquire about the
project but would not be participating. As it turned out, all inquiries except one, who did not meet the criteria, were eventually approved by myself for participation. It should be noted that participants were completely self-motivated to partake in this study and no active soliciting was done by any one person, not even myself. A script for telephone information was used to provide information about the study (see Appendix B). A mutually agreed upon time and place were then scheduled with each participant to be interviewed.

I met with each woman at a place of her choosing. Each participant was given a script outlining the process for data collection (see Appendix C). I believe that by providing participants with as much information as possible, trust between the participant and myself could be established. Each participant was asked to complete consent forms (see Appendix D) and a brief biographical survey (see Appendix E). I felt that it was important for the participants to be fully informed about the study and the use of the data. Consequently, I had participants sign two consent forms, one for the University’s Human Subjects Review Committee and one for my use. Interviews were recorded on one of two small hand held microcassette tape recorders. During the interview, I felt that it was important to accept the view of the participants as being important and accurate enough. This belief is in keeping
with the feminist view that women's instincts and feelings should be trusted and acknowledged. Consequently, data were not "checked" against some other source for accuracy.

I asked each participant the one set question and then opened up the interview to the participant to discuss anything about their depression. Most interviews lasted from 45 minutes to an hour and a half. During the interviews, notes were taken to assure no loss of data due to mechanical failures. Notes also reflected some of the observations and thoughts that I had.

After each interview, I made notes on my impressions and thoughts as I walked away. A reflexive journal was kept to document decision making and any biases or conclusions made by myself from my "tacit knowledge" (Patton, 1990). Each interview was then transcribed, mostly by myself. Two interviews were sent out to be transcribed by one hired person from another location. After the tapes were transcribed, each participant was contacted within a week or two for a second interview to review the transcription. Reviewing consisted of the participant making any changes or requesting that some information be left out. Participants were also asked to complete a review of transcription form to confirm the accuracy of the transcription (see Appendix G).

This session was again recorded on a microcassette recorder in case there was further discussion of a point or
new information was to be obtained. I again took notes of the participant's reactions to the data and my thoughts. The recordings from the second interview were not transcribed verbatim because participants either said little or provided no new information. Often the conversation had more to do with "seeing words in print" than with depression. Two participants requested to review the transcription in the privacy of their homes and that wish was granted. All changes or revisions were made at the request of the participants, and participants were then sent a finished copy of the transcription for their own use.

Data were not analyzed in process due to time constraints; however, initial impressions of data were shared with each participant.

Lincoln & Guba (1985) outline how to know when enough data have been collected. The authors suggest one of four criteria that allow a researcher to stop collecting data: exhaustion of sources, saturation of categories such that there are only tiny increments of new data, emergence of regularities (integration), or overextension (removed from core concerns). The authors recognize that reality often dictates the end of data collection as funds run out or deadlines arise. Glesne and Peshkin (1992) also suggest that the researcher stop collecting data when one has reached theoretical saturation or redundancy in the data. Nevertheless, these authors also recognize that data
collection may end due to many other factors, such as lack of money, time, or energy. For myself, data collection was terminated after seven participants for several reasons. I felt that the data were approaching saturation as conversation topics were quite consistent. In addition, resources appeared to be exhausted as I received no additional inquiries for this study. There was also the reality that many participants left for summer break, and new participants could not be as easily recruited during the summer months.

Plan for Trustworthiness

Lincoln and Guba (1985) suggest steps that a researcher may take to achieve trustworthiness. Those steps include: maintaining field journals; mounting safeguards against distortions; arranging on-site team interactions; triangulating; gathering reference materials; providing debriefing for participants; and developing and maintaining an audit trail of inquiry. Trustworthiness in this study was achieved by leaving an "audit trail" that was available for the dissertation committee to review. The audit trail consists of the raw data (transcripts), the coded transcripts, the data analysis steps, and the self-reflexive journal. In addition, some reference materials in the form of information pamphlets were gathered for analysis. These pamphlets were collected at nearby mental health clinics in
which students in general frequent. Also, participants were debriefed during a second interview by providing whatever insight into the analysis I had at that time, and participants were able to edit their own transcripts. I was not able to do a formal data analysis as I was interviewing and transcribing at the same time, but I did have a sense of where the data were heading.

Field journals were not maintained in the sense that extensive, daily notes of a prolonged engagement in the field were kept. Rather, some observational notes were made concerning each of the participant's environment, and notes on my impressions of the participants were written. Likewise, the techniques of triangulation and developing safeguards against distortions were not used, mostly because of the desire to accept information from participants as their perspective only. Triangulation to prevent researcher bias was not possible because other researchers were not readily available to work on this study, and additional data gathering was too costly both in terms of money and time. These same reasons precluded the use of on-site team interactions.

I also gave extensive thought to doing member checks of the data and the analysis. A major problem in doing member checks was the time constraint in doing the interview, transcribing the data, analyzing the data, and returning the information to the participant within a week or two.
Similarly, other peers had reported a problem with "draining participants," in that participants needed to be available to review the transcription, comment on the data analysis, and provide a full second interview. Those same peers were unsure that the additional work yielded significant additional data. I was also concerned with prolonged engagement with participants because of the possibility that participants may become dependent on me as a social worker and confuse these interviews with therapy.

**Protection of Participants and Confidentiality**

The confidentiality and protection of participants were strictly maintained by keeping data locked in a cabinet. Raw data from participants were given number codes so that no names nor identifying information were connected with the transcriptions. Two transcriptions were sent to an outside typist. Although interviews were transcribed verbatim, all identifying information was removed from the data. Participants could also request the removal of words or complete sections of the transcripts during the second interview. Participants also had the opportunity to make further comments on their depression during the second interview.

Token compensation for the participant’s time was in the form of movie passes or gift certificates of five dollars per meeting (a ten dollar maximum for two
interviews). Certificates seemed to be more personal than money as the interview represented the sharing of information, not the buying or demanding of information. Participants in crisis were referred to the Counseling and Consultation clinic on the campus. One participant was referred and the data were not used as she was seeking therapy. Likewise, participants who requested therapy were referred to the Counseling and Consultation clinic; two participants made this request. I felt qualified to recognize participants in crisis or suffering from severe depression and to offer referral assistance since I have worked with the chronically mentally ill and I am a Licensed Social Worker in the state of Ohio and certified as a social worker in Michigan.
CHAPTER V

FINDINGS AND DATA ANALYSIS

The meaning which the researcher attributes to any behavior must be identical to the meaning the individuals to be researched attribute to that behavior if it is to be correctly understood. (Mickunas, 1983, p.7)

Data Analysis Techniques and Procedures

As noted previously, no research is done without some subjectiveness surrounding it. Similarly, no data analysis can be done without the researcher's subjectivity. Mickunas (1983) states that "there is no purely objective social data, only data which are interpreted within a specific socio-historical context" (p. 1). Furthermore, Mickunas (1983) suggests that "scientific researchers . . . must also assume a tacit understanding of values and meanings which play a role in the selection, interpretation, and evaluation of data" (p. 7). Thus, alertness to one's own biases and subjectivity can assist in producing more trustworthy interpretations of data.

Several other authors have made suggestions concerning the process of qualitative data analysis. Marshall and Rossman (1989) imply that the analytic procedures for qualitative research to be the following: organize the
data; generate categories, themes and patterns; test the emergent hypotheses against the data; search for alternative explanations of the data; and write the report. Each suggested phase involves data reduction and interpretation by the researcher who attempts to convey the meaning and insight of the participants to the readers. These phases of data reduction and interpretation can be somewhat mysterious as each phase somehow brings out the meaning of the raw data. As a result, careful attention to how the data are reduced is necessary so that important information is not lost due to the researcher's preference. On the other hand, a researcher needs to be careful to not reduce qualitative data and lose its inherent strengths to an overly mechanistic data analysis.

Thus, when organizing the data, Marshall and Rossman (1989) suggest that the data should be read over and over again. The data are then "cleaned up" to make the passages more readable, but the researcher needs to keep in mind that even the punctuation has an interpretive element to it. The next phase, the data analysis phase, is the most difficult because of the crucial generation of categories, themes, and patterns. This analytic process demands heightened awareness of the data and an openness to subtle information. Questioning the data and reflecting on the theoretical framework helps to shape the data into understandable, identifiable categories. These distinct categories reflect
a constructed topology, not separate language categories. Again, judgement by the researcher as to what is really significant and meaningful shapes the categories. Patton (1990) suggests that categories be judged on internal homogeneity and external heterogeneity. The author also suggests prioritizing categories, although this implies hierarchal thinking. In short, the process of data analysis involves both technical and creative dimensions. The inductive search for patterns is ultimately guided by the evaluation questions identified at the beginning of the study and focuses on how the findings are intended to be used by the intended users.

Testing emergent hypotheses, the third step, involves looking at the plausibility of the developing hypotheses and testing them against the categorized and patterned data. One way to test the emergent hypotheses is to search through the data for negative instances of the patterns and incorporate those instances into larger constructs. Marshall and Rossman (1989) note that during this phase, the researcher should evaluate the data for information adequacy, credibility, and usefulness. The researcher must then determine whether the data are useful in answering the questions being explored and whether the data are central to the story that is unfolding. One way to determine this is by searching for alternative explanations so that the researcher challenges the very pattern that "makes sense."
Alternative explanations always exist; the task is to search and describe them so that others may decide if the original explanation makes the most sense.

Lastly, writing the report is part of the analytic process because the researcher chooses the words to reflect the data. Again, the researcher is engaged in an interpretive act. The presentation of the data gathered through in-depth interviews and observations needs to reflect the participants’ perspectives. The researcher simply needs to accept that participants have presented a particular side of themselves and not interpret that perspective. When writing the report the researcher may then chose to relate the presentation to a theory or a perspective of the researcher’s choice.

Glesne & Peshkin (1992) indicate that "data analysis involves organizing what you have seen, heard, and read so that you can make sense of what you have learned" (p. 127). They suggest that data analysis be done simultaneously with data collection and that impressions from the interview be written in a personal journal or reflective field log after each interview. They also suggest writing down first impressions while transcribing the data. In addition, the authors strongly recommend writing monthly or quarterly reports to committees or funding institutions in order to keep the research process going in one direction and reflect on what the researcher has accomplished.
When analyzing the data, there are several considerations and choices that researchers make. Those considerations and choices are influenced by the theory from which the researcher is working. For example, researchers working from a feminist theory and research model will tend to explain all activities in terms of race, class, and gender. This explanation is not necessarily wrong, but it may not be the sole possible explanation. In the same way, error can result from the unconscious interpretation of data which occurs as a result of methodological assumptions. In other words, data are distorted to reflect the evaluators' beliefs, not necessarily the beliefs of those who are evaluated (Murphy, 1983).

Furthermore, not only are there presuppositions from the interpretation or write up of the data, but the language used just to ask a participant a question presumes a particular response. Moreover, the evaluator is not in a position to determine which presupposition constitutes a valid understanding of the respondent (Pilotta, 1983). In short, if ideas about etiology are to be tested, researchers need to get beyond therapy-based interpretations of the individual and deal with the meaningfulness of the experience for the individual without leaving ourselves open to the accusation that we have simply imposed our interpretation of data ad hoc (Bogden & Biklen, 1990).
Writing the Findings

Writing up the findings from a qualitative study provides a unique opportunity for the researcher because data can be easily displayed through example. The study can be written up such that excerpts from interviews can be integrated into the text. As mentioned previously, finding the exact language to convey the data and communicate themes, patterns, and processes can be difficult, especially when the data are open to the researcher's interpretation. On the other hand, conjectures, speculation, and interpretation should be left up to the researcher who knows the data best. The researcher, therefore, becomes the "translator of culture" which again suggests the need for the researcher to constantly reflect on his/her own subjectivity (Glesne & Peshkin, 1992). When writing up the data, the researcher needs to select the excerpts that best tell the "story" of the participant and construct a text which is part plan, part intuition (Glesne & Peshkin, 1992). Likewise, Lincoln and Guba (1985) suggest that the researcher provide the reader with as much information and raw data as possible so that the reader has the opportunity to make his or her own connections.

Van Maanen (1988) discusses ethnographic writing types. This particular work most closely resembles "critical tales" as they are fashioned to illuminate the larger social, political, and economic issues of the society. Van Maanen
(1988) further discusses limitations of writing up data by asking several questions that each researcher needs to answer: In what ways does the researcher in the research process shape the final story? What political relationships share the final interpretations? What is the theoretical position of the researcher? How do narratives limit the portrayal of the researcher's interpretations? For this study, the answers to these questions should be rather evident already or will certainly become evident in the following chapters.

The author also points out that the historical situating of observations and interviews contribute to limitations as does the projected audience in shaping the form and substance of the product. From the beginning, I have emphasized that this study is based on the perception of the participants at one point in their lives and my observations while interviewing participants in 1992. As for the projected audience, dissertations as a rule are not widely read by the general public; however, I have made an attempt to write without using academic jargon in hopes that this work could be more easily understood by many individuals. In particular, in keeping with feminist ideology, I have attempted to write in a way that is meaningful to women.
Generalizability

A large criticism of qualitative research is the lack of generalizability. Not all qualitative researchers are concerned with generalizability; those who are, explicitly state that the study is not generalizable. Some researchers focus on which other settings and subjects findings can be generalized to. Others feel that careful documentation will allow others to decide what the study can be generalized to. I do not believe that generalizability is an issue for this study. I feel that other standards of good research, particularly for qualitative studies, can be established that reinforces the worth of qualitative research without making generalizability the central issue. Focusing on forms of validity and reliability may be that standard.

Validity and Reliability

There is a constant discussion of "rigor" as the mark of "good" science (Strauss & Corbin, 1990). Unfortunately, most of the discussion has centered on making qualitative methods fit quantitative standards. Lincoln and Guba (1985), one of the first to address this issue, attempt to fit qualitative research into standards of internal and external validity and traditional reliability. In fact, the description of reliability and validity provided by non-qualitative social scientists may not be appropriate or relevant to the way qualitative work is done.
Unfortunately, qualitative researchers are not as advanced as other scientific practitioners in talking about what they do as far as methods are concerned (Kirk & Miller, 1986). Given this point, it is even more difficult to discuss standards of reliability and validity in qualitative studies. Nevertheless, Kirk and Miller (1986) suggest that objectivity is still the "essential basis of all good research" (p. 20). The authors define objectivity as the "simultaneous realization of as much reliability and validity as possible" (Kirk & Miller, 1986, p. 20).

In terms of validity, asking the wrong questions actually may be the source of most validity errors, suggesting the need for the researcher to know the "lingo" and issues as expressed by the respondents (Kirk & Miller, 1986). For that reason, Lather (1986) suggests that validity could be based on other standards such as triangulation which makes use of multiple measures, data sources, researchers or methods. In addition, Lather (1986) proposes the standard of construction validity which questions whether the constructs are really occurring or merely inventions of the researcher's perspective. Another suggested validity standard is that of face validity, best described as the "click" of recognition or reaction from respondents in the form of member checks. Lastly, Lather (1986) suggests making use of a new standard of validity, catalytic validity. Catalytic validity is the degree to
which the research process reorients, focuses, and energizes participants toward knowing reality in order to transform it.

Lincoln and Guba (1985) suggest that credibility should be a factor in "good research." This credibility may be based on peer debriefing, negative case analysis, referential adequacy, and member checks. Likewise, credibility through additional data, prolonged engagement, and an audit trail (tape recordings, transcripts, notes, coding, etc.) should be made available to others. In addition, a self-reflexive journal could be used to provide account of thoughts, observations, and decisions, thereby increasing credibility. The use of a "peer debriefer" has also been suggested as a means of increasing credibility in the process of collecting and analyzing data.

In a similar way, other forms of reliability could be used to judge research. One of those forms is synchronous reliability which refers to the similarity of observations during the same time period. Kirk and Miller (1986) suggest that different investigators may observe different parts of the same scene/group and come to different conclusions based on who they are and what they see. This information could be valuable because the different researchers may be on to different aspects of a large complex subject. In short, partial understandings may be better in this case as
multiple findings may provide more information than only one understanding.

For this study, the criteria for credibility suggested by Lincoln and Guba (1985) have certainly been met by providing an audit trail that consists of the raw data (tape recordings), the transcribed data, the observational notes, a reflexive journal, and each step of the data analysis which will be presented. Unfortunately, a peer debriefer was not available for this project; however, I was able to share ideas, methods, and outcomes with peers via the research courses in which I was enrolled. In terms of synchronous reliability, I believe that this form of reliability has much promise but is not feasible for an individual work such as a dissertation.

Moving on to validity standards, Lather's interpretation of validity standards seem most appropriate for this study. Although I was not able to obtain validity through triangulation, I feel that an adequate case could be made for good construction, face, and catalytic validity. I feel that good construction validity is evident in the data presented. I believe that the phenomena that emerged from the data reflect the participant's reality, not my invention. That data is to follow. In terms of face validity, I was not able to do member checks of the data analysis with the participants. Nevertheless, I felt that there was a "click" of recognition from the participants
that I understood what they wanted to convey. Perhaps that understanding was based in my training as a clinician or in my status as their peer. Lastly, I believe that the participants who talked so openly about their depression showed considerable focus on their problems and the energy to search for answers. Thus, I feel that the study reflected good catalytic validity in supporting the participants' search for meaning.

**Data Analysis for the Study**

This was an inductive data analysis. Data were evaluated in September and October of 1992 and again in January of 1994. The first time through, data were coded for all ideas or themes, not just words or sentences or paragraphs as in a literary analysis. Codes were then listed on a master list. Codes which were found to have multiple meanings were adjusted by renaming one of the codes (figure 1). Similar codes were then grouped into named categories (figure 2). Categories were then regrouped as the initial groupings were too cumbersome. Occasionally codes had to be reviewed such that the data were re-read for contextual relevance. At this point, codes were lengthened to provide greater meaning and if necessary, sections of the data were recoded using the lengthened codes. Those groups were categorized again without labeling the categories (figure 3). Categories were then rethought and reorganized
ES=escape
SB=siblings
SS=Self-sacrificing
M=moving
SE=Self-blame
BI=Body-image
TO=time off
F*=female/feminist
BL=being liked
E=eating/food
CN=control/helpless
TA=talking
OW=overworked
SL=sleep
CL=classes
DN=doing nothing
OD=others don’t know
MI=minimalizing
#=suicide
L=loss
CR=crying
M=mothering
PA=paralysis
RES=responsibility
HUM=humiliated
SD=self-destructive
LAZ=Lazy
NH=no hope
D=depression
V=violence
F=friends/roomies
G=grades
O=others first
B=boyfriends/rel.
ST=stress
T=time
TH=therapist
WO=world
DR=draining
MN=money
DA=doing alone
TR=trust
IM=impatience
DU=don’t underst.
FG=feeling guilty
RA=race
DI=divorce
PMS=pms
CO=coping
AC=accidents
IN=introverted
DRV=driven
INS=insane
PRO=procrastinate
SI=self-image
P=parents
H=Happy face
S=suicide
W=weight
C=caring
I=illness
A=appearance
SN=in synch
SU=support
WR=worries
FT=fate
R=ruminating
DE=deserve more
GU=growing up
AL=alone
RL=religion
TR=tired
PB=pushing back
AN=anger
LV=love
CIR=circumstan.
OH=others happy
TCL=tolerance
HN=have nothing
PRE=pressure

Figure 1

Codes for Data
People/relationships:
   SB, P, F, B, TH, SU, OD, DU, M

Circumstances:

Feelings:
   NH, D, GL, AN, CR, LV, TR, IM, PB, TOL, HUM

Self:
   SS, SI, SB, O, EE, PMS, CO, SD

Appearance:
   A, E

Alone:
   ES, TO, SL, DA, DN, AL, PA

Overwork:
   DR, OW, R, DE, MI, OH, DR, IN, PRO

Role:
   H, C, BL, TA, MO

Figure 2
Initial Categories for Data
<table>
<thead>
<tr>
<th>PMS</th>
<th>Draining</th>
<th>Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introverted</td>
<td>Overworked</td>
<td>Caring</td>
</tr>
<tr>
<td></td>
<td>Driven</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Insane</td>
<td></td>
</tr>
<tr>
<td>Being liked</td>
<td>Doing things alone</td>
<td>Appearance</td>
</tr>
<tr>
<td>Best</td>
<td>Alone</td>
<td>Self-image</td>
</tr>
<tr>
<td>Deserve more</td>
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<td>Weight/eating</td>
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<tr>
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<td>Religion</td>
</tr>
<tr>
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<td>Talking</td>
<td>Divorce</td>
</tr>
<tr>
<td>Make others happy</td>
<td>Escape</td>
<td>School</td>
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<tr>
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<tr>
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<td>Sleep</td>
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<tr>
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</tr>
<tr>
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<tr>
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<tr>
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<td>Boyfriend</td>
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<td>Time</td>
<td>Control/helpless</td>
</tr>
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<tr>
<td>Mothering</td>
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</tr>
<tr>
<td>No hope</td>
<td></td>
<td>Feminist/female</td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guilty</td>
<td></td>
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<tr>
<td>Love</td>
<td></td>
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</tr>
<tr>
<td>Tired</td>
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<tr>
<td>Impatience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pushing back feelings</td>
<td></td>
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<tr>
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</table>

**Figure 3**

Recoding and Regrouping
Figure 4). Figure 5 demonstrates the named categories and some minor recategorizing was necessary so that all codes were used. These were the final categories. Finally, categories were thought of in terms of causes, symptoms, and results and sectioned accordingly simply to see if any other information emerged (figure 6). This analysis yielded some insight in that categories could be thought of in multiple ways or that it is simply too difficult to determine whether a factor is a cause, symptom or result of depression.

In the second analysis, the data were again read through but this time only salient points to the study were underlined and coded. The points to underline were based on the previous analysis and intuitive relevance. These codes were then listed per participant so that a list of that participant’s themes were created (figure 7). All codes were then listed and grouped for similarity. A matrix was then written such that grouped codes were marked off for each relevant participant. For example, if the grouping was violence/rape and that code appeared in data from participant 1, 4, 5, and 6, then an "x" was placed under that category for those participants (figure 8).

From these matrices, most frequently marked categories were considered to be "major" findings. Nevertheless, particular findings were not discounted simply because they were not the most frequently cited problem associated with depression. I did not want the analysis to degenerate into
Being liked  Appearance  Doing alone
Being the best  Self-image  Alone
Deserving more  Body-image  Introverted
Support  Weight/eating
Doing nothing  Self-destruct  Mothering
Paralysis  Self-sacrifice  Make ot. happy
Procrastinate  Self-blame  Happy face
Lazy  recategorizing  Others before
Growing up  Responsibility  Caring
Loss  Don’t know  Time
Religion  Don’t underst.  Synch
Money  School/cl/gr  Circumstances
Race  World  Fate
Violence  Control/helpless
Circumstances  Draining  Accidents
Fate  Overworked  Illness
Control/helpless  Driven  PMS
Insane  Stress  Pressure
Minimalizing  Siblings  No hope
Escape  Parents/Div.  Depression
Ruminating  Friends/room.  Guilty
Eating  Boyfriend  Anger
Sleep  Time off  Love
Talking  Tired  Depression
Coping  Humiliated  Guilty
Therapist  Tolerance  Anger
Suicide  Pushing feel.  Love
Crying  Impatience

Figure 4
Rethought Categories
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<th>Goals not attained</th>
<th>Poor self-image</th>
<th>Being alone</th>
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<td>Alone</td>
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<tr>
<td>Deserving more</td>
<td>Body-image</td>
<td>Introverted</td>
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<tr>
<td>Support</td>
<td>Weight/eating</td>
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<table>
<thead>
<tr>
<th>Unable to do any.</th>
<th>Giving up self</th>
<th>Doing for ot.</th>
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<tbody>
<tr>
<td>Doing nothing</td>
<td>Self-destruct.</td>
<td>Mothering</td>
</tr>
<tr>
<td>Paralysis</td>
<td>Self-sacrifice</td>
<td>Making ot. hap.</td>
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<tr>
<td>Procrastinate</td>
<td>Self-blame</td>
<td>Happy face</td>
</tr>
<tr>
<td>Lazy</td>
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<td>Ot. before self</td>
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<tr>
<td></td>
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<td>Responsible</td>
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<td>Don’t know me</td>
</tr>
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</tr>
<tr>
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<td>School/cl/gr</td>
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</tr>
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</tr>
<tr>
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<td>World</td>
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</tr>
<tr>
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<td>Violence</td>
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<td>Depression</td>
</tr>
<tr>
<td>Friends/room.</td>
<td>Control/helpless</td>
<td>Guilt</td>
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<tr>
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<td>Anger</td>
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<td>Insane</td>
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Figure 5
Final Categories
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<td>Doing for others</td>
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<td>Time of life</td>
<td></td>
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<td>Social/life</td>
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<tr>
<td>Lack of under.</td>
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<td>Neg. emotions</td>
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<td>Neg. emotions</td>
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<td>Poor coping</td>
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<tr>
<td>Poor coping</td>
<td>Physical</td>
<td>Physical</td>
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<tr>
<td>Pressure</td>
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<td>Better coping</td>
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<td>Physical</td>
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Figure 6

Causes, Results, and Symptoms
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<td>Weight</td>
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<td>Depression</td>
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<td>No support</td>
<td>Calling friends</td>
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<td>Keep trying</td>
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<td>Pressure</td>
<td>Forcing self</td>
<td>Force self</td>
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<tr>
<td>Exhausted</td>
<td>Fate</td>
<td>Doing everything</td>
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<tr>
<td>Too much time</td>
<td>Self-destructive</td>
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</tr>
<tr>
<td>Good coping</td>
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<td>Resentful</td>
</tr>
<tr>
<td>Therapist</td>
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</tr>
<tr>
<td>Desire to be happy</td>
<td>Compelled</td>
<td>Alien to family</td>
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<td>Others’ opinion</td>
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Figure 7

Participants’ Themes
Figure 7 (continued)

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<td>Hypersensitive</td>
<td>To be needed</td>
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Viol=vioice/rape
Body=body image/weight/thin
No sup=no support (particularly from family/mother)
Blame=self-blame
Coll=college/campus/classes
Oblig=obligation/guilt/responsibility/doing for others
Tired=tired/sleeping/paralysis/stagnation/no motivation
Phys=physical symptoms

<table>
<thead>
<tr>
<th>Theme</th>
<th>Cont</th>
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<th>Alone</th>
<th>Relat</th>
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Cont=control/fate
Couns=counselling/therapists
Alone=alone/isolated
Relat=relationships (lack of or poor)
Front=putting up a front/happy face/facade
Money=money/financial problems
Cry=crying, sadness
Press=pressure

Figure 8
Charting of Major Themes per Participant
Figure 8 (continued)

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Grow = growing up
Suicide = suicide
Oth = talking about others
Force = forcing self to keep going

Analysis was made of the themes of each participant suggesting the following:

Four of the seven touched by violence
Pressure of image affects some
Feeling no parental support via disagreement or distance
Pressure of college/campus
Obligation/responsibility/guilt to take care of others
Force self to keep going
No motivation/stagnation/paralysis
Physical problems—exhaustion, stomach, tmj
Sense of no control
Sense of isolation, being alone, loneliness, wanting to be alone
Lack of relationships or a poor relationship
Need to put up a happy front
Little to no counseling
a mere exercise in counting as this process takes away from the importance of an experience shared by fewer individuals. I believe that there is a danger in assuming that more frequently cited themes are always more important than less cited themes. On the other hand, redundancy in data does demonstrate greater validity for that data. Nevertheless, I wanted to look for all the possible factors that have traditionally been overlooked and for that reason, I have included some less frequently cited themes. In conclusion, results remained very similar despite different data analyses concluded at different times. Likewise, there did not appear to be negative instances in either data analysis.

**Data Results**

The results obtained from this study are quite similar to those found by Miles (1988). This was most encouraging since Miles used a similar theoretical perspective and methodology. One similarity was that Miles found participants often blamed themselves which she felt was consistent with the desire to be in control, whether for good or bad. Certainly, the participants in this study had much to say about control, although there did not seem to be a level of blame but instead, a sense of obligation. Like the housewives in Miles' study, these participants felt that they were responsible for the lives and well-being of their families. Unlike the women of Mile's study, these
participants did not have their own families, but felt obligations toward their family of origin.

In addition, Miles (1988) found that women feared placing too many demands on close friends and relatives as they did not wish to be a burden to family members and friends. There seemed to be an assumption that women should be caretakers for others, even to the point of neglecting their own care. Miles also found a great value placed on social support by participants, although support often deteriorated as depression continued. Support was also an important issue for participants in this study, especially support from their mothers. In my data analysis, I found other issues, perhaps more particular to younger women, that the participants associated with their depression. The following analysis demonstrates what these young women associated with their depression.

**Violence**

When the participants were asked about their present level of depression, most replied that they were past the most severe state of depression but suggested that their depression was still constant and on-going in their daily lives. One possible reason for this on-going depression may be the violence in their lives. Results of the data analysis indicate that four of the seven participants were touched by violence. Two out of seven participants had been
raped and one participant had witnessed the results of the physical abuse of her sister by her sister's husband. Another participant had been molested by a physician.

Regardless of when the violence occurred, the effect of the violence continued to haunt their daily lives. The fear and anger that the women expressed helps to illustrate how oppression plays a part in the daily lives of these women. The contribution of violence to rates of depressive symptomatology in women has long been neglected, partly because victimization histories tend to be ignored or conceptualized as the source of a personality disorder (Bryer, Nelson, Miller, & Krol, 1987). For the women in this study, violence occurred at the beginning of their adulthood, robbing these young adult women of their hope and trust in the future.

#1 "Well, I guess we'll start with the rape because that has probably been the biggest and most significant part, I mean that's what's caused a great deal of this depression and having difficulty getting out of that state. It's been very, it's like climbing out of a hole. I try to get up but it's so hard."

#4 "First, school, then last semester I really had a very bad experience with my gynecologist. I had never been to a male before. And I feel that he did some really inappropriate things to me. I consider myself to be molested but I did not have any proof and so I decided not to pursue it. And that comes up sometimes. I don't lie. But it happened and so it kind of added to this thing. Just kind of like out of it. I don't know. I don't think about that much. It does come up sometimes."
#5 "I’ve lost my compassion; I’ve lost . . . you name it. It’s just not there right now. So, the reason I went to see him [therapist] is because I realized that I’m lacking it and I realized something is wrong right now but I don’t know how to get past that point and I don’t know . . . see, he told me that there’s things in my past that I haven’t dealt with yet. So I’m trying not to resurface those things. In February I was raped here on campus. And I thought I was fine because I thought I let . . . but when we were talking, we were just talking about different things and he said, have you ever been raped before? And I just looked at him because that’s not something you ask out of the blue and he said that he felt that I had had some kind of problem like that and he was wondering if that’s what it was."

#6 "My sister’s marriage didn’t work out . . . she went through a very violent time and I got to be the one who brought her home. I mean stick with her at three o’clock in the morning while the family was asleep. They didn’t know her neighbors had called____. She was eight months pregnant. Her husband had smashed her head against the wall; he had kicked her in the stomach and she had a footprint on it and it was a violence that I had never seen. She kept her whole marriage, the violence in the marriage to herself; she never talked about it."

Self-Image

The pressure of trying to project some type of socially approved female image seemed to create depression in several participants. Some participants felt pressure to look a particular way and other participants felt pressure to project an image based on the opinions of those around them. There is little question that women feel social pressure to look and behave a particular way (Faludi, 1991). The pressure can become very oppressive and depressing but, as
the following excerpts suggest, a few participants fought the pressure and display their anger.

#1  "I started doing a little better then and then the boyfriend I started dating, I totally . . . wouldn’t take me out because he didn’t like the way that I looked or he thought I weighed too much."
   "Yeah, because I look at myself and I think if I were somebody else, would I hang around with me?"

#3  ". . . I don’t think of it exactly the same any more but in high school, I used to look at the other people . . . because when I see photographs of myself sometimes I feel like, oh, I look really Jewish, I’m really strange."
   ". . . sometimes when I feel like I do look good, I’ll look at the Ohio ID picture and wonder if that’s really fake and I wonder if what I see in the mirror is really what other people see because I don’t know that I can trust that because then I see these awful pictures and when other people go yeah, but look at my driver’s license and they pull it out and it looks like them. That really bothers me if mine look just like me then. . . ."

#4  "Well, I don’t like myself very much. It seems weird that people say, well, how could you have a self-esteem problem and I think I do. It’s just been that way for a long time. I know that I have been insecure. Very unsure of myself. Even though I have done well, I mean its weird."

#5  ". . . And I’ve done things like . . . like I don’t shave my legs any more. And that’s just out of spite for males, completely and totally, you know? I mean some people joke because it’s, it’s o.k., granted I save ten minutes in the shower---and that’s nice but a lot of it, I will admit, and very immature to do it out of spite for males but, you know, at least I don’t have to worry about them coming up and talking to me because they don’t, you know?"
   "No, because I look like shit to me, that’s fine. I can look like shit for me if I want to
look like shit because---you know what I mean? I’ve figured out that I do respect myself enough to look the way that I want to be, you know what I mean?"

School-Related Demands

Participants talked about pressure from school in general or specific classes. Certainly, pressure is expected from being in school. Inside the classroom, there is pressure to finish assignments and the competition among peers to succeed. Outside the classroom, living expenses force many students to work long hours at minimum wage jobs. The harsh realities of trying to get an education affected these participants as several of them mentioned their concerns about school.

#1 "I had to go to the professors, ask them for incompletes, tell them what happened (rape). A few of them said we don’t care; you weren’t in class for it, we aren’t going to help you out."

#2 "Yeah, you should see my phone bills. Out of sight. Because I came here only a year and half ago and I am taking 25 credits every quarter on top of 20 hours of work a week."

#3 "I actually caught one of them [classmates] cheating. I saw it and looked around and I couldn’t believe it. The teacher said, ‘well, I understand but there is nothing I can do.’ What I thought was, well, because she didn’t see it; I thought, well, this has been going on for the last three quarters."

#4 "Because when you are a student, it is just ridiculous. You have classes all week, then you have to spend the rest of your time preparing, so
you really, even Sunday night, you cannot really enjoy because you have Monday. You have to be ready for something. Saturday, you feel guilty all day if you do something other than study. Friday night, you are so bushed from the week, you are like, I should study but I am so tired and so I am going to blow this day. You just always feel---at least in school there is this tremendous pressure to study all of the time."

#7  "I don’t know what this is a function of but when I was in college, the students were not drawn into political issues in the department; grad students, graduate school is a different animal."

**Lack of Support from Parents**

Among the participants, there was a sense of feeling that they received no parental support whether it was due to disagreements or simply physical distance from their parents. In any case, the feeling of not being supported by the people that one may depend on for support is very painful. Wetzel (1984) finds that dependence can be defined as a state of helplessness based on the inequities of the social environment and that those socialized for dependence may never get out of it. Wetzel goes on to note that although independence may reflect psychological maturity and well-being, so does being connected to others, belonging, and giving and receiving social support (Wetzel, 1984). In this regard, Wetzel suggests that family may not be supportive of a daughter’s independence as it upsets the status quo. Families may not realize that “authentic nurturance requires neither the giving up of the self nor
the protection of another’s fragile ego. It is, instead, the support of what is alive and growing . . . " (Wetzel, 1984).

#1  "I didn’t tell them [parents] then either [about the rape]. I waited a year and a half before I told them. Well, they had big problems of their own to work out and I ended up getting involved in their problems."
   "My parents were always on my back about things. And, of course, I made them unhappy."

#3  "I think she [mother] really tried to understand, not everything considering she’s perfect. She used to model. She is gorgeous. I don’t think she understands what it feels like to not look pretty. She is not really like your typical mom. That’s something she never had to worry about. Like in high school, I used to have fights with her because I was kind of fat. She would say, well, if you think you are fat, do something about it . . . ."

#5  "That’s another thing I figured out. I just . . . she is a very wonderful person, she’s my mother but she’s kind of like everybody else like she cares more about herself than anybody else which when it comes to it, you have to care about yourself . . . ."
   "I think maybe if he (father) saw me, he would see it, you know? If he . . . if he could see the way that I walk instead of the way I usually walk; if he could see just different things, you know? And my . . . at least—anything! I think he would see that it’s really terrible but over a phone, you know, two and a half hours away."

#7  "I’m still very close to my family and a lot of my satisfaction, a lot of my motivation comes from my family and—recently I have found it harder and harder to accept the fact that my parents keep going back to another country. They come over and they’re here for two months and I just get used to calling my mom and talking to my
mom on the phone and depending on them just to be there. And then they're gone."

**Responsibility and Obligation**

A major finding suggests that participants felt an overwhelming sense of obligation or responsibility for the happiness of others. This sense was mostly manifested in the desire to take care of others. A good deal of research has been conducted on the source of obligation for women to act as caretakers for elderly family members. I believe, however, findings from this study indicate that the socialized obligation to assume responsibility for caretaking begins much earlier. It should be noted that the participant's birth order was not a factor in their sense of obligation and responsibility as participants varied widely in their birth order.

Newmann (1987) has suggested how this obligation to care for others may be related to depression. Women may be exposed to more interpersonal stresses and they suffer from the "emotional cost of caring" for loved ones. Likewise, women may be "taking on" the stress of others due to their greater emotional involvement in the lives of those around them. Kessler and McLeod (1984) noted that women are also more likely to be sought out as supporters during times of crisis; consequently, when women are already overloaded with their own problems, these extra problems create a greater sense of depression. This greater "range of caring" may
thus expose women to a greater risk of depression. All of the participants in this study expressed their feelings of obligation or responsibility to care for others and some mention their guilt when they do not take care of others.

Furthermore, some women expressed dismay over the lack of reciprocity. These young women appeared to feel that they had already given so much only to get nothing in return. I could not ascertain whether these participants felt an obligation to care for others because they felt that this was the only way in which to get care in return. Perhaps this is a result of feeling undervalued by society and not deserving care without giving something first.

#1  "He (the boyfriend) had his problems, dragging them in and dumping them on top of me plus my parent’s problems, plus my own."
    "For years I was thoughtful of my friends in sending cards and letters and I don’t get the same thing in return and that depresses the hell out of me because I try and go out of my way to remember things and do things for people and I neglect myself in the process is what ends up happening. Then I feel bad and upset with those people afterwards."
    "I give too much of myself and I end up feeling terrible afterwards because nobody gives back that much."

#2  "I couldn’t even go on vacation when I wanted to go because I had to be somewhere around my family and I just know that nothing is happening while I am away."
    "So we came to America but first year was a mess because we don’t have credit cards, we don’t have driver’s license, we have to find a job and then we have to find a better job, then we have to go to school, then my parents get divorced and I have to support them. . . ."
#3 "I love doing it (having others over for dinner) but people don’t really reciprocate even as far as my family."

#4 "I feel that if I am really supposed to be this Christian person first and I am supposed to be all happy and cheering other people and that I have to be giving advice and here I am totally depressed."

#5 "It’s (depression) been for a few months but I’m one of those people that a lot of people depend on so I have to be the shoulder for everybody else. So, I kept putting my feelings and putting my feelings back and now they’re surfacing and I can’t put them back any more which is why it’s so strong right now because I’m not--- I’m more of an optimistic person."

"I do so much for people. And I’m not, I don’t expect them to do the same back to me---but show that you appreciate it."

#6 "He (the counselor) said that I have a problem with caring and worrying. He said you worry about what is happening at home and there’s a lot of problems my parents are going through because of all the things happening back home. I carried this along and with it the frustration that I haven’t been able to help out."

#7 "And here I am trying to deal with my sister’s having these problems and everybody is holding me responsible because we roomed together that year so I could help her."

"That’s a big thing. If I don’t take care of people or something, I feel really guilty. I’ve always had a problem with that. My brother will be up here and I want to have a real good time for him but then he’ll leave and I’ll sit around and cry because I feel so guilty because I think I didn’t do enough, or I think about stupid little things I’ll feel so guilty about."

Another interesting point about this finding was the length of time that participants spent talking about other
people. Two participants talked about their sisters at length, and all participants talked about their families to a large extent. Participants focussed on others even in the discussion of their thoughts and feelings. This information may point to the degree in which the participants constantly think about others and do not focus on themselves.

**Overcoming Paralysis**

A parallel finding to the participants’ sense of obligation was that most women have to force themselves to keep going despite the paralysis that comes with depression. These women often mentioned having little motivation to do anything, but they appeared to feel the same sense of obligation, guilt, and responsibility to get up and do what they needed to do or perhaps what others expected them to do.

#1 "My mom even said when you are sick, you keep going, you keep going. But, you can be physically sick that is one thing, but when there is a mental or emotional problem, it’s not that easy."

#2 "But what is interesting it doesn’t really bother me too much. I know of, knew that I was sort of . . . I’m depressed. Well, I’m depressed. Now what are you going to do about it? Nothing. Just live through it."

"No, because I just know with that kind of schedule I can’t afford to be sick, I can’t afford to be depressed. . . ."

"Because last quarter it (courses) just got me really down. Because I thought I was doing terrible, I don’t know why I’m doing this (working so hard), this is torturing me. . . ."
#3  "Yeah, but it's not long term (sleeping all
the time) like that will happen on the weekend,
but I know that during the week I have places that
I need to go, things that need to be done and I
have to get up and get out of the house. There is
no way that I can't; there is nobody to pay my
rent or anything. I have to get myself up."

#7  "If I did this (sleeping a lot) all the time,
everything would suffer. I would probably lose
everything and that's one thing that keeps me
going, I think, is the fact that I don't, and
maybe the perfectionism is part of the solution
for me because it keeps me from just lying down
and saying, gosh, I'm just so depressed; I'm
not---I can't do anything."

Putting Up a Facade

In addition, there was a feeling among the participants
that they needed to put up a happy front for others. Many
suggested that they force themselves to smile so that others
will not worry about their depression. I believe this point
is also associated with the participants' sense of
obligation and responsibility. Nevertheless, most of the
participants expressed a dislike over feeling "forced" to
put up a happy facade, and some participants simply refuse
to do that any more.

#2  "People kind of don't know that I am
depressed because I can bitch at no one in terms
of my action, I don't express it in any kind of
way."

#4  "Yes, I have to be happy and then I have to--
-I feel like everybody wants me to give them
something and I don't feel that I have anymore to
give, so I feel because I can't give it, I become
very grouchy lately."
"Yes, I mean---because they just want instant results they want me to perk up and be this happy go lucky person who is going to just do everything they want me to do."

#6 ". . . You smile and go along. No, why should I smile? You know, I'm not having a happy day."

"In this society, especially for women from my background and economic level, you've always got to maintain a facade. You always have to explain everything as ok if your husband abuses you, it's just not discussed."

#1 "I know. Because in my family we are all very strong people; you know we have to show people that we are not weak. It's almost like men and crying; you have to put on that strong, strong outer surfaces that says I am strong and I can handle anything."

"No, if I'm upset, I am upset. I'm not going to try to put on a front for anybody; if my parents don't like it, that's too bad because this is my problem (the rape) and this is what I have to deal with."

**Physical Symptoms**

Not unexpectedly, the participants mentioned a very real physical linkage to depression. Depression has been highly correlated with a range of physical disorders (McGrath et al, 1990). An interesting point in this study was the severity of the physical problems that these women endured. Women reported not just feeling tired, but being drained, having stomach problems, and even dealing with TMJ.

#2 ". . . I didn't realize how tired I was . . ."

"I want to deal with my depression somehow differently because there is another---if I'm depressed I have to go for a walk, or for a drive,
or even forget about everything and go to (home) for three days. But I don’t. I know it’s good for me, but instead of that I kind of think that I have to work. So I end up staying on the couch all day long doing nothing."

#3 "Usually when I am heavily depressed, I am the opposite; I sleep all of the time. I just stay up here in bed."

"There are times when I don’t feel like doing anything but sitting around."

#4 "I feel tired. Even if I have had a lot of sleep. I think it is just, it may be a mental thing. I just feel drained."

#6 "I developed stress problems and I’ve been trying to understand what was the root of this because medicine didn’t help, I’ve been to almost nine doctors, $2000.00 worth of tests."

#7 "So this quarter has been especially hard on me---and thus, I’ve broken out and my hair’s been falling out and my TMJ has, well, actually I, I came down with my TMJ this month and, not this month, this quarter and my doctor, my dentist said that I should avoid stress in these situations."

"I become incredibly accident prone when I’m depressed. It is weird because when that happened when I had bronchitis. I get run down when I’m depressed and I get sick a lot."

Lack of Control

An interesting finding was the discussions on control. The participants all noted the lack of control that they felt in relationships, school, and other obligations. A sense of control is central to theories of learned helplessness (Seligman, 1975); yet, I find it difficult to conclude that the lack of control that these women felt was
in any way learned or socialized. I think that their loss of control is a very real part of being a woman in this society as all participants wanted control of some area in their lives, but they were not lacking in control in all areas of their lives. At the very least, participants' lack of control could be both learned and a real part of women's lives. At any rate, the sense of helplessness and defeat when that the participants felt no control over important aspects of life certainly added to their depression.

#1  "I'm tired of allowing someone else to control my life and that's what happened. Ever since that day (being raped), someone else has taken control of my life except for me, whether it be him, my parents---someone has always held the little puppet strings and said here, go do this and that."

#2  "When I have to take mandatory courses I know that I don't need them for the purpose of what I'm studying. So it feels like it's imposed on me, someone's will and I don't like anyone to say that I've got to do it."

"And that's (school work) very very uncontrollable, because over this I have no control and that's simply scary because I find myself in a new situation when I would put myself in a situation when I have to write my doctorate thesis."

#3  "I think that's part of the problem as far as emotionally because I never, no matter how hard I try, it never feels like I get everything under control. That's probably the one thing that I try really really hard is getting control. The money thing and the life thing, the whole school thing, everything. I can never control; it feels like everything is always chaos and I can't control it and that bothers me. I should be capable."
#6 "Nothing that I could control and what I had to learn which I want to talk to a counselor is that he said it's not your problem. You didn't create these problems."

"He (the counselor) said you are a person who comes across, you are a very rational person with full control of your life but you cannot control someone else like you want."

#7 "Anyway, this control issue---I think that's a frustrating factor in my relationship with my boyfriend because I can't control anything."

Isolation and Being Alone

Among some of the participants, there was a sense of isolation; however, the women in college mentioned the desire not to be alone while the women in graduate school appeared to want to be alone as they saw others as being "a drain." Graduate school is set up to promote independent thinking, working and living. As noted earlier, McGrath et al. (1990) suggested that women who are in school may find that the demanding training environment leaves little time to develop social ties, and some women may even believe that social ties are detrimental, competing with their academic agendas. In addition, it may be that involvement in social relationships may be less protective for women as problems and strains in these relationships, on top of academic demands, increase their risk for depression. Again, this point may be tied to the participants' sense of obligation, and some participants may have simply learned to avoid some
relationships in order to cut down on the amount of caring
that they will ultimately feel obligated to do.

#1 "It's difficult to take and the daily
stresses and pressures also cause a lot of
depression when you are just sitting here in your
room waiting for somebody to come and visit you to
give you that little study break that you want."

#2 "So I don't like parties, because if I have
to go to a party I feel like I'm working real
hard. So basically I have to be alone quite a
bit. So when I'm depressed I'm still alone but
then I'm sitting at home like right now, sitting
at home I feel fine."
And I don't want to share a house with
anyone because people would talk to me all the
time because I'm responsive if you start talking
to me and I just plunge in right away and I start
talking. But that taxes my reserves. 
Energetically I don't know I just perceive a lot
of people as energetic vampires or something."

#4 "It's hard being in a big school. I think
that is part of it all. I felt isolated and
alone. Because at college, you lived in a big
house with other women. Kind of like you had to
have meals with people. You see everybody every
day. Whereas in a graduate dorm, you can stay in
your room and never see people if you don't want
to."

Relationships
A correlation between poor or no relationships and
depression in women has long been noted (Jack, 1991; McGrath
et al., 1990). In this study, participants have associated
poor or no relationships with their other issues of control,
being alone, or feeling unsupported. Jack (1991) supports
this by noting that women report feeling "isolated and
lonely within relationships of inequality and emotional distance" (p. 165). Some participants noted poor or no relationships with boyfriends. Jack (1991) has noted that women may feel guilt, shame, and depression as the result of a failure to maintain intimate ties. Jack also suggests that self-esteem for women is related to the quality of attachments and relationships such that women may find it easier to handle stress when there is a significant attachment.

Other participants specifically noted poor relationships with their mothers as being a source of depression for them. A number of empirical studies have reported that depressed women recall their parents, especially their mothers, as unaffectionate, withdrawn, and overcontrolling (Blatt, Wein, Chevron, & Quinlan, 1979; Parker, 1979). However, these studies suggest that depressed people may selectively remember and perhaps exaggerate negative experiences. I tend not to believe that each participant’s view of their mother is exaggerated. Instead, I would suggest that participants perceive their mothers more negatively than they perceive their fathers because they too are socialized to believe that women are socialized to be responsible for the happiness of others.

#4  "I think I just had a lot of problems with my relationships. My mom is very overbearing and we got into a lot of fights this year."

"Then I have a steady boyfriend and we have been dating for two and a half years. Then I came
here and then things started to fall apart with school and he was feeling that I didn’t have enough time for him. And me feeling like I have nothing else to give, so it was like take what you can get."

#5  "I went out with somebody for two years, I went out with somebody for _____ and I’ve always had very long relationships until I went to college and now I don’t even have one guy."

#6  "And one of the things that I always argued with my mother is that she never hugged us."
   "I was home because the situation was that I could talk to people but now that I’m miles away, very frustrating because my mother would pick up the phone and said I want you to know that a crisis is happening. . . ."

#7  "A source of---I don’t want to say a source of conflict but a source of pain is my relationship with my boyfriend because he is gone for eleven months now; I have no idea where we stand so we have our periodic phone calls and then I’ll take one good thing he says, blow it out of proportion."

Therapy

Finally, I was struck by how little counseling or therapy women sought when they were depressed. None of the participants was presently seeing a therapist but most had sought therapy at one time or another. These women did not continue with therapy past a second session. Perhaps looking at what they say about therapy can provide some insight into why these women did not continue with it and what professionals can do to reach out to these women when they need help.
#1 "... The professionals told me you are depressed—look at the way you are handling things; you're not handling anything."
  "... this is what's wrong with you so just snap out of it."
  "I feel like the counselling didn't help because what they do is, at least the people I've encountered, except for the one woman who had cancer, they basically sat there and tried to tell me what my problem was. It wasn't like we talk together; it was you have this, you're exhibiting these signs."

#2 "You can be depressed, as depressed as you want to, but this is just a time to relax. So I'm kind of depressed but I know that this is a restoration process."

#4 "I don't know if it is just a cultural thing because historically life for the Afro-American in this country has been difficult and I think a lot of them feel that you have to be tough, you have to deal with it and you cannot buckle under pressure."

In addition, while most of these participants were not actively in therapy, three out of seven openly mentioned that they had considered suicide at some point in their lives. Participants were offered referrals for therapy if they requested it, and those who mentioned suicide were encouraged to seek treatment.

#1 "I couldn't leave my room; I totally withdrew from everything. That was the only time (after a rape) in my life I ever felt what you might say is
suicidal-like. I just didn’t want to go on because I just didn’t feel like there was anything left."

#4 "There have been times when I want to stay in bed. One of the times, I thought about suicide, which is really funny because I don’t think I have the guts to do it. It is so funny because you are probably suicidal and look at you as if you are crazed. Oh, no, you are thinking about suicide. I really don’t think I have the guts to do it, even though it has crossed my mind several times. I just don’t think that I would do it. I really don’t."

#5 "I know that I’m going to be ok; I know that I’m not going to commit suicide because I wouldn’t do that, you know what I mean?"

"Right, I was thinking that I didn’t want to be alive. I sometimes think I could really just go off. There are so many parts in the world that you could just go off and live and no one would even have to know about me."

Second Interviews

I returned to interview participants a second time and allowed them to review their transcriptions and ask questions. When asked to comment on transcription in terms of accuracy, all but two felt that the transcription was accurate; those two were rather recent immigrants and perhaps did not realize how poor their English really is. In terms of feelings, three felt the words reflected a more upbeat feeling and two felt that words were too dark. I allowed participants to make changes to their transcriptions, and one participant took out whole blocks to hide her identity. Another participant kept the
transcription for four weeks since she did not have time to go over it in my presence (she was leaving for a short summer break). Nevertheless, this participant made few changes. Two participants felt that they had more to say; however, it may be that given the rapport they felt with me, they wanted to continue for the purpose of therapy.

My written observations of these women during the interviews indicate that all participants were obviously pained talking about their depression. Some participants even cried at some point in the conversation. In terms of additional useful information, the second interview provided little additional information. Nevertheless, I believe that it was important to allow participants a second chance to say anything, to review their words, and to make any changes to the transcription. Some quotes are provided below to give an indication of what was said during these second interviews. In addition, some of my observational notes are provided for review.

#1  "I have nothing else to say---I've said it all."
   "I have a tendency to give myself totally to other people's needs and attentions and neglect myself and I need to stop doing that and I need to pay attention to myself."

#2  This participant took out a long discussion of her previous country. She appeared more depressed when I went back as something happened that she didn't want to discuss--can't sleep, can't eat, can't work. She says "sometimes I feel angry but most of the time I just sit and cry like crazy." (Later, participant mentioned that a
friend didn't want to see or talk to her anymore.) The participant admits to putting on a happy face but cries in her room. "It takes a lot to make me cry." She thinks that the transcript is boring.

#3 The participant feels that she is always in a bad mood. She claims to have responded to the sincerity of flyers and feels more comfortable talking at home. She felt that the transcription was a "trip to read." The participant feels that she is doing better as she was moving to a new place.

#4 This participant had nothing new to add and didn't want quotes from relatives to be included.

#5 "I don't have much to say, you know? Nothing to add." Participant talked about her real concerns about financial aid for next year. She believed that it was a "slap in the face" to have 3.85 GPA and only be granted a 300 dollar academic scholarship.

#6 The participant was not happy with the transcription and did not believe that she spoke in that way. We, therefore, negotiated some of the transcription.

#7 This participant had nothing to add and spent time chatting about recent campus events.

**Self-Reflexive Journal**

I wanted to give a brief indication of what the notes from my self-reflexive journal were like. Several notes indicated the huge emotional drain of collecting data as discussions with participants tended to bring up my own issues of depression. In addition, my notes indicated an overwhelming feeling concerning the amount of transcription;
most interviews consisted of twenty to twenty-five single
spaced typed pages. I also wrote of my concern with member
checks as I was fearful of draining participants. It seemed
to me that member checks of the analysis began to look too
much like therapy, suggesting that I knew what their
problems really were, and I did not want to take away from
their views.

Additional Data Analysis

In addition to the main data analysis, I reviewed five
common pamphlets on depression available at centers where
these women could conceivably receive help. I "coded" the
content in them to decide if most women have some media-
induced ideas about depression. I found that the emphasis
of the pamphlets was on the hormonal differences or chemical
imbalances within depressed individuals. One pamphlet
suggested that women have "social permission to express
emotions." Nevertheless, it appeared that these
participants were not affected by media coverage of the
popular belief in biological causes over other factors. The
participants seemed to rely mostly on their intuition and
experiences from their daily life as none of the
participants talked about biological causes or pre-menstrual
syndrome. At most, one participant thought about the
possibility of inheriting her father's mental illness. I
think that this finding indicates the need to continue to
explore social factors associated with depression even with the event of genetic and chemical breakthroughs.

Limitations

Several limitations can be associated with this study. A debatable limitation of this study is that only one small group of women at one point in the life cycle was studied. Nevertheless, focusing on one point in the life cycle does appear to help in limiting the many factors known to be associated with depression, thereby providing more accurate answers to questions about depression for a particular group of people. The related limitation is sample size. Patton (1990) notes that researchers decide how much time and effort they will invest in understanding any one person’s experience. I made the decision to take the time to look at the issue of depression in depth and detail versus breadth, given that almost all studies on women and depression have focused on breadth. It was hoped that the by going into depth, taking the time to understand a few women’s experiences, new information on women and depression will have emerged. In addition, it was my hope that this small study could conceivably be the beginnings of a larger study at some later date.

In that same regard, the sample does not account for women not described in the focus of this research. This sample consisted of educated participants from varied
backgrounds; I believe that results may be very different when not using a sample of college students as their perspectives may be very different. Another limitation encountered in sampling was the use of international student participants. Initially, my belief was that their issues of depression would be associated with very different factors as they face different societal pressures or beliefs. I relented on this stipulation, however, because the international participants had been in this country for at least five years, suggesting that their language skills would be adequate to convey their perception of their depression. I was also curious to find any similarities among the participants.

Limitations in the methodology of this study, based on qualitative procedures, also exist. It was unfortunate that member checks could not be completed as I believe that checking of the data analysis by the participants themselves may have provided more accurate and insightful results. On the other hand, I believe that draining participants is a very real issue in research. I did have participants review their transcription and make modifications if they wanted. As a result, some data were "lost" and some were modified to the participants' liking. My reason for allowing participants to review their data was in keeping with the feminist belief that information was "shared" and that the participants "owned" the data until they were ready to give
it away. Nevertheless, I have few qualms about the "lost" data because people are multifaceted beings and most research can only capture "slices" of people at any one time. Thus, if a participant wants to present a particular side of themselves and not another, we, as researchers, may simply need to accept that.

Another methodology limitation was that a second intense interview was not done for this study because participants were quite unwilling to do that. My original intention was to do two interviews; however, participants seemed to feel that they had "said it all." I think that it is understandable that participants may have felt emotionally drained after the first interview since they were very open. In addition, I did not seem to have any problem building rapport and trust immediately as I was their peer, thereby lessening the need for a second interview. Although the advantages of being a peer can be demonstrated in rapid rapport with participants, I believe that there is some limitation to this due to the effect of familiarity with some participants. Some participants may have had a higher level of comfort that others were not able to have. Nevertheless, I do not feel that it limited self-disclosure as participants were telling me things that I never knew even though I knew these acquaintances for some time years.
A limitation previously mentioned was the lack of time between data collection and on-going data analysis. I do believe that on-going analysis would have provided better direction in subsequent interviews. In addition, I was the only coder, opening up the study to perhaps too much bias. Nevertheless, there has been some discussion as to the notion that all research projects have this problem and an audit trail has been left for review.

Utility of the Research

The major utility of these research results is that they demonstrate a negative case example and raise questions about the validity of established theories of depression. As an inductive study, the results are not intended to prove a theory but rather, "to develop an ideographic body of knowledge in the form of 'working hypotheses' that describe the individual case" (Lincoln & Guba, 1985, p. 38). The results, then, should help to understand people in the way they see themselves. In doing so, we break through both the stereotypes of women and of the illness of depression that govern our behavior.

In addition, the perspectives of the participants bring to our attention the "patterns of behavior and features of the physical environment in order [that we may] be more analytical about regularities that may unknowingly govern their lives" (Bogdan & Biklen, 1992, p. 216). Thus, if
reality is constructed by people as they go about living their daily lives, then people can be active in shaping and changing their lives and the lives of those around them.

Bogdan and Biklen (1992) believe that:

The usefulness of the qualitative perspective to practitioners is related to seeing all people as having the potential to change themselves and their immediate environment, as well as becoming change agents in organizations in which they work. Qualitative research skills can play a part in helping people to live in a world more compatible with their hopes by providing tangible information on what it is like now. (pp. 216-217)

This study provides information on the lives of young adult women who are suffering from depression and illustrates what needs to be done to change their world.
CHAPTER VI

DISCUSSION AND CONCLUSION

Since depression is often a progressive illness, lack of treatment and lack of attention to the specific needs of depressed women are tragic, unnecessary losses. (McGrath et al., 1990, p. xi)

The Social Construction of Depression

Depression as a social construct is not a new idea. Depression as a social "ill" was put forth by George Brown (1984) who divided social factors into provoking agents, which determined when depression was likely to occur, and vulnerability factors, which made an individual more susceptible to depression. Provoking agents include death, serious illness, the break up of a marriage, and the threat of eviction. Vulnerability factors include the lack of a supportive relationship and lack of employment. The author concluded that "there is good reason to believe that depression is not just another problem but a central link between many kinds of problems—those that may lead to depression and [those] that may follow from it" (Brown & Harris, 1978). Similarly, Miles (1988) has suggested that medical categories and the very notions of illness and disease can be viewed as social constructs; she concludes
that the prevalence of depression may, therefore, suggest what is wrong with society. While sadness, unhappiness, and grief may be socially inevitable, depression does not have to be inevitable (Brown & Harris, 1978). This conclusion supports the relationship of personal troubles to public issues, in line with feminist theory.

Clinical Implications

A major finding in this study suggests that the source of depression for these participants may be an obligation to care too much. This obligation to care may well be part of the socialization process for girls. Certainly, an argument can be made that society encourages and even rewards women for being caretakers, making it difficult for some women to learn "where to draw the line" in terms of sacrificing their own health for others. Society may also be encouraging these women to put up a facade for others and force themselves to overcome their own paralysis so that others may not suffer for it. Thus, at a relatively early age, the women of this study have learned to put the care of others, particularly their family members, friends, and significant others, above their own care needs.

Likewise, the women felt a true sense of having little control over people, work, and events. I do not believe that this is due to "learned" helplessness, but rather a conflict within women in which they feel the social pressure
to be responsible for relationships and events but are not
given the power to control those things. This point can
certainly be illustrated in the participant’s concerns about
relationships and the effects of violence in their lives.
Perhaps as Brown (1984) suggested, these findings could be
viewed as an indication of what is wrong with society, not
necessarily what is wrong with the individual.

Another clinical implication is defining mental
illness. In using diagnostic categories, we are captives of
clinical terminology, so much so that concern with symptoms
and syndromes tends to neglect the role of the current
environment and a person’s strengths in combating it.
Furthermore, classification can be used in support of any
explanation of psychiatric phenomena (Brown & Harris, 1978).
As noted, the labels of mental illness tend to hide the
social nature of illness and the reality of sexism in
society. Subsequently, it is easier and more obvious to
blame the individual for his or her problems.

Perhaps, then, the first obstacle to providing services
for those who suffer from depression is the lack of
consensus about how to define depression (DiNitto & Dye,
1987). As long as depression is defined within the
individual, individuals will be blamed for their own
illness, and policies concerning the poor and the depressed
will reflect this thinking. I believe that social workers
need to return to their position as advocates for social
change and not allow the continuation of a predominantly female psychiatric population to be diagnosed, psychoanalyzed, researched, and hospitalized by predominantly male professionals who view the source of depression to be within the individual (Chesler, 1972).

**Research Implications**

Many fields are turning to qualitative research "out of desperation as well as inspiration" (Wolcott, 1990, p. 11). The usefulness of qualitative research cannot be underestimated. As this study indicates, not only does qualitative inquiry bring out useful, perhaps overlooked information, but it stimulates a discussion of research definitions, methodology, validity, objectivity, ethics, and goals. Likewise, types of qualitative methodology, such as feminist methodology, bring to the forefront, issues involving the acceptance of the perception of participants, reciprocity in the data gathering process, and the possibilities for emancipatory research. Qualitative research can also open discussion of research techniques, such as the need to consider the necessity and ways to build rapport with participants. Nevertheless, I do not wish to encourage researchers to think dualistically, that it is qualitative versus quantitative methodology, relativism versus objectivism. Instead, as Gould (1981) states:

I do not intend to contrast evil determinists who stray from the path of scientific objectivity with
enlightened antideterminists who approach data with an open mind and therefore see truth. Rather, I criticize the myth that science itself is an objective enterprise, done properly only when scientists can shuck the constraints of their culture and view the world as it really is... Science, since people must do it, is a socially embedded activity. It progresses by hunch, vision, and intuition. Much of its change through time does not record a closer approach to absolute truth, but the alteration of cultural contexts that influence it so strongly. (p. 21-22)

Research implications also include issues involving research with women and research on mental illness. For too long, research has not included women because women have been viewed as the "other" and men as the "norm."

Consequently, simply more research is needed on women and the issues that affect their lives. In terms of mental illness, research is quickly turning to a preference for just biological and medical research. With all the cries for more and better treatments for illnesses, the trend to support and believe in simple biological causation is understandable. People want a quick and easy explanation and treatment for their problems and more importantly, no society wants to accept any responsibility for mental illness.

In the past, individuals have been blamed for their depression in terms of their poor coping skills or other personal failings. Biological theories that support the notion of individuals having "chemical imbalances" take away that blame. On the other hand, that same notion can be used to support biological determinism which may ultimately limit
the opportunities of many individuals. It is my conclusion that the need for social or environmental research on mental illness is sorely needed to keep focus on a more holistic or even biopsychosocial explanation of mental illness.

In terms of future research, McGrath et al. (1990) suggests that "basic research needs to be conducted that focuses on refining conceptualization and measurement of variables related to the psychological traits, social roles, and life circumstances, as well as depressive-related symptoms, syndromes, and disorders over the life cycle" (p. 7). I would add that additional research on how different groups of people view different types of mental illness could be very enlightening. This inductive, exploratory study has pointed to a new direction for future studies on women and depression. That direction is to look at women's sense of obligation to care, their desire for reciprocity in caring, and the subsequent detriment when women care for others to the exclusion of themselves.

In addition, I was struck by the number of women exposed to violence. As more research is done looking at the actual numbers of women exposed to violence, I think that there is a real need for research on the subsequent depression or other problems that develop in those who are victims. This study also touched on the lack of treatment obtained by these participants, and I believe that researchers should look at why these women left therapy and
what professionals can do to get people the help that they need. In addition, similar research on the etiology of men’s depression may be of interest given their very different lives.

Lastly, I think that this study illustrates the possibility of researching mental illness via self-identification. Most studies of mental illness obtain participants through clinics or private therapists, thereby introducing the possibility that those with a mental illness who seek help are different from the population that may have the same illness but do not seek help. In the case of those who suffer from depression, the often paralyzing aspect of the illness itself makes it difficult for people to participate in any extensive or time consuming studies, let alone be openly seeking participation in a study. As a result, I believe that this study indicates that there are those who would volunteer to participate in a study of this nature and that there may be some difference between this type of participant and a participant obtained via clinics or therapists.

Theoretical Implications

Data are most often reported in terms of some theory and theories are not culture free. Many theories of depression exist and inform research; however, feminist theory is really just beginning to be applied in a more
specific fashion to mental illness, specifically, depression. In this same way, social work theory has long been somewhat vague and undefined as social work theory "borrows" from the theories of other disciplines. Nevertheless, I believe that a combination of feminist and social work theories can be usefully applied to both research and practice issues that social workers deal with everyday. In this study, feminist theory not only guided the research methodology, but provided a useful tool in explaining depression in women. I do not believe that other theories of depression are necessarily incorrect, but certainly this theory offers another point of view that brings to light elements of depression in young women that may have been overlooked using other theoretical orientations.

One theoretical implication, therefore, may be the feminist view of caretaking. As noted, caretaking appears to be a socialized expectation for women while men seem to be more free from caretaking and are encouraged to be independent and separate from their families. This may well help to explain some of the differential in the diagnosis of depression. The expectations for women are clearly different than those for men, and young adult women in this study appear to feel the pressure of the expectation that they will care for others. In this regard, the social pressures for women have not changed even though
expectations of women in this society continue to change for better or worse.

**Practice Implications**

Given the general belief that depression lies within the individual, health professionals have been addressing women’s needs in this way. Weissman (1978) notes that "traditional therapies encourage women to adjust to social situations in which they are helpless and which are depressing" (p. 2). Although therapy can be an affirming experience, often it is not. Once in treatment, bias emerges as female clients tend to be blamed for their own coping inadequacies. For example, when a case of depression is associated with learned helplessness, in which a woman feels no control over her situation, assertiveness training is often the prescribed mode of treatment (Kiefer, 1990). By prescribing assertiveness training, the individual is blamed for her own coping inadequacies and is encouraged to improve her low self-esteem. This mode of treatment assumes that women should be more like men and fails to deal with the wider oppression that women experience.

In addition, women are encouraged to take medications for depression. Again, Weissman (1978) states that:

Although there is good evidence for the efficacy of antidepressants in reducing the symptoms of depression, there has been concern from those involved in women’s issues that women may be overmedicated in order to encourage them to adjust to intolerable situations which, in fact, might
require social and political change. Therefore, clarity as to what conditions and on what outcomes we can expect the different treatments to be effective may help us to understand their utility. (p. 5)

There is a very real question of whether medications encourage dependency, passivity, and a victim mentality in women, and thereby reinforce depression. Interestingly enough, antidepressants and the structured therapies have about the same success rate for depressed women with less severe disorders (McGrath et al., 1990). That is good news given that the drop out rate for using antidepressants can be as high as sixty-seven percent (McGrath et al., 1990).

Kravetz (1976) points out that mental health professionals could be criticized for helping to perpetuate an adjustment-oriented system that limits women’s opportunities for personal growth and their participation in society. Traditional methods of interacting with clients limit practitioners in their efforts to change women’s situations personally, socially, and economically. (Liddie, 1991). Social work has often adopted sexist theoretical frameworks upon which to base its array of services. Psychoanalytic theory, which came out of the European middle class male perspective, is the basis for most caseworkers’ orientations and has for a number of years been questioned for its gender bias, sex role stereotyping, and class bias.

Women are consistently presented in the theory as innately passive, dependent, anatomically inferior and
emotionally immature (Kravetz, 1986; Sturdivant, 1980). The client is usually viewed as being the "owner" of his or her behavior and therefore responsible for his or her life circumstances such that the focus of therapy is on changing that individual's behavior. This focus negates the impact of external factors that impinge on the individual's efforts to cope. Many critics of traditional theories and practice point out that we need to look beyond the individual client to the roles of those institutions that are responsible for, or at the very least perpetuate, the debilitating pressures on women's lives.

Likewise, in working with individuals who are living in marginal conditions, social workers often find it easy to focus on the problem areas while ignoring environmental factors. This focus prevents clients from feeling empowered enough to recognize their own strengths to change the systems around them. Social workers are also taught that although institutional change is necessary, it takes a long time, so that, in the meantime, social workers should use strategies and interventions to help people adapt to their current conditions. On the contrary, to alter the client's oppressive personal, social, and economic situation in a positive way, social workers can use methods to produce institutional changes in the near future, preferably through encouraging clients to exert pressure for those changes themselves.
Given that two-thirds of all clients are women and the majority of social workers are women, social work practice with women, particularly depressed women, should place more emphasis on how women experience life; in short, social work practice perhaps should be based on feminist principles (Wetzel, 1986). Feminist practitioners, in general, are concerned with the ways in which patterns of institutionalized sexism create problems for all persons, women in particular. As previously stated, there is a consistent belief in the societal or cultural origins of the distress experienced by women (Bricker-Jenkins & Hooyman, 1986). Feminist social work practice is defined by its approaching all issues presented by social living and social relationships and by identifying their implications for women.

As noted previously, social work practice and feminism share many common values (Wetzel, 1986). The center of feminist social work practice is political practice—a directed effort to enable people to control the conditions of their lives by creating more egalitarian power distributions (Bricker-Jenkins & Hooyman, 1986). Feminist social workers have a commitment to the development of specific actions and techniques to remove barriers (Bricker-Jenkins & Hooyman, 1986). Some of these techniques are consciousness-raising, emphasis on process, and validating a woman's experience.
Social workers need to motivate women to action within their therapeutic treatment so that barriers to full human potential such as institutionalized sexism and oppressive relationships can be overcome (Morell, 1987). Accordingly, female clients need to be fully active in all phases of treatment, and practitioners need to focus on reciprocity. Therapeutic goals should include self-help and the sharing of resources, power, and responsibility, thus making the personal political (Kravetz, 1986). Social workers also need to consider what the "personal is political" means for the daily reality of women. Specifically, social workers must consider how resources can be directed to those material conditions that women experience as most oppressive and debilitating—poor housing, unfulfilling work, inadequate child care, and victim-blaming (Bricker-Jenkins & Hooyman, 1986).

Moreover, social workers need to depathologize the therapeutic process by avoiding labels and focusing on specific strengths that have evolved from women's attempts to deal with their oppressive circumstances. In short, practice needs to be oriented to the goals of social change, otherwise social workers simply maintain the norms of the larger society by viewing many individual behaviors as "sick," including those behaviors that are used to deal with life pressures. If the norms are oppressive, then social work can be seen as oppressive or, at the very least, as an
agent of oppression if it follows those norms (Liddie, 1991). In sum, sexual inequality undermines psychological development and personal achievement (Morell, 1987).

In the last 20 years, research has looked at different types of treatment for depression. Different forms of psychotherapy were compared with each other and with psychopharmacology. A review of studies published from 1974 to 1984 concluded that the combination of psychotherapy and drugs was more effective than were placebo conditions which entailed minimal contact (Conte, Plutchik, Wild, & Darusus, 1986). Nevertheless, the results of 17 studies indicated that the combination of therapy and drugs was only slightly superior to psychotherapy alone, psychopharmacology alone or either of these treatments combined with a placebo. In a study of 59 participants with recurrent unipolar depression who were treated with medication and interpersonal psychotherapy themselves, and whose families attended a psychoeducational workshop, Kupfer and Frank (1987) found that the relapse rate after eight weeks was only 8.5 percent. I believe that these findings support the need to look at mental illness, particularly depression, in a more holistic way, and I feel that feminist social work practice can provide the means to a more holistic practice.

As social workers, I believe that we are in a better position than other mental health professionals to deal with the problem of depression because we understand how social
systems affect individual mental health. It is now social work's obligation "to design, evaluate, disseminate, and implement powerful responses to eliminating the oppression of women" (Collins, 1986). The social work profession needs to understand and incorporate feminist perspectives and theories, not only as a way to understand the personal lives and problems of females, but also as ways of understanding our patriarchal culture (Collins, 1986).

To summarize, as mental health workers, we are trained to see mental illness, such as depression in a particular way—in an individual context (Ehrenreich, 1985). However, social workers recognize that if the source of people's problems is socially based, then social change is the answer. The number one mental health problem may well be the intersecting of racism, sexism, and poverty. In this case, social problems need to be solved through social action, such as helping women find decent housing, fulfilling jobs, and assisting them in exercising their rights as human beings. That is not to say that social workers should ignore biological or hereditary influences on the development of depression. Rather, social workers need to maintain their holistic, biopsychosocial perspective in their view of depression and assess for societal and environmental factors in their client's lives.
Final Thoughts on Theories of Illnesses

Brown and Harris (1978) question whether researchers should study "illness" or "illnesses." Researchers know that social stressors raise susceptibility to disease in general so that perhaps researchers should begin to study disease as a whole. Some sociologists suggest that the trend in Western societies is to interpret social and emotional problems within a medical and psychiatric framework (Miles, 1988). After all, people increasingly turn to doctors for every little problem, thereby stretching the boundaries of medical care and creating a "medicalized unhappiness." Perhaps researchers should consider why many people take their problems that are "a part of life" to doctors and why doctors feel obligated to treat those problems. These problems that cause so much unhappiness are then given a medical explanation that renders the individual and society blameless. Perhaps it is more acceptable to be thought ill than to be thought of as inadequate or a failure. There is also pressure on psychiatrists to provide treatment for unhappiness and focus on "prevention." Thus, psychiatrists are very ready to prescribe pills that give some temporary relief from symptoms.

Miles (1988) also questions whose interests are served by the "inventing of neurosis" and what is the motivation of those who apply this label to individuals. Labeling has a profound effect on individuals and those who view those
individuals. In addition, definitions of health are imbedded in the culture and the situation such that diagnoses are often "negotiated" in conversations between doctors and patients, "a process that suggests that psychiatric illnesses are 'social constructions'" (Sands, 1990, p. 21).

Another concern is stated by Bader (1989) who notes that psychiatrists have been losing ground for years to related professions. The author believes that the psychiatric profession has thus encouraged an emphasis on psychopharmacology and neurobiology to foster the dominance of psychiatrists and encourage society in general to adopt biological explanations for depression. As noted above, even with findings that suggest a relatedness of biological and psychological states, the research in this area does not prove causation. Too often biology is used to suggest the source of depression for females instead of a consequence of depression. It may well be that depression is the "cause" of chemical imbalances. I also believe that there should be a real fear in suggesting biology to be the sole cause of mental illnesses. In the past, biological research has been used to disable women and keep them from opportunities. On the other hand, biological research has also freed women from traditional roles, such as through the discovery of more reliable forms of birth control. In sum, I feel that this research is a prime example of researchers confusing
symptom with cause, a misconception that has grave implications for not only women, but those with any mental illness.
CHAPTER VII

SUMMARY

Feminist research is, thus, not research about women but research for women to be used in transforming their sexist society. (Cook & Fonow, 1986, p. 13)

This study was based on the fact that women are diagnosed with depression at almost twice the rate than men (Newmann, 1987; Ridsdale, 1986; Sidel, 1986). Many associations had been considered as possible explanations for women’s higher rates of depression; however, none of the associations appeared to provide the complete explanation for these higher rates. There remained the question of why are women more likely to be depressed than men? The assumption was that the etiology of depression in women was somehow different from the etiology of depression in men such that the major research question was what is it in the daily lives of women that leads so many of them to become depressed?

The justification for doing this study in the way chosen was that, in general, most explanations of depression had emphasized the role of women and the individualistic, idiosyncratic, and innate qualities of women, rather than
the greater social problem of sexism and the oppression to which women are subjected (Sidel, 1986). In addition, few studies had directly asked women about their depression and fewer still had considered allowing women to self-diagnosis their depression. Thus, this study focused on both women’s "inner selves and outer lives" (Jack, 1991).

Through an inductive, exploratory process, new insight into the perspective of depressed women was gained by listening to what they had to say about their depression, their environment, the people in their lives, and themselves. The study focused on a social construction of depression, using feminist and social work theoretical perspectives. One objective of this study was to have women describe their depression as it manifested itself in their daily lives. Participants were encouraged to describe how their depression felt, how it affected their work and their relationships, and anything else that seemed most important to them. The second objective of this study was to consider what young women perceived to be the source of their depression in the belief that women had some understanding of what created their depressive feelings in their lives and that there was similarity in those beliefs among the women.

Generally, studies of depression have looked at groups of women who were thought to be the most stressed, such as young women with children or women who are unhappily married or women who have suffered a loss. In contrast, this study
considered whether a less established risk group--young, adult, educated, single women with no children--had elements in their lives that lead to depression. The sampling technique of purposeful sampling with maximum variation yielded a sample that consisted of seven women from varied backgrounds. This type of sample provided high quality, detailed descriptions of each case and important shared patterns that cut across individual cases.

This study made use of feminist theory which emphasizes that institutionalized sexism creates problems for all people and that the distress experienced by women has societal and cultural origins (Bricker-Jenkins & Hooyman, 1986). In addition, feminist research methodology was used "to put the social construction of gender at the center of one’s inquiry" (Lather, 1991, p. 71). The goal of this type of research in the human sciences is "to correct both the invisibility and distortion of the female experience in ways relevant to ending women’s unequal social position" (Lather, 1991, p. 71). Thus, feminist theory and research methods guided this research project and seemed most applicable to the principles social work theory and practice.

Depression can be considered to be a complex, multi-faceted syndrome but basically, the definition of depression has never really been adequately or fully defined (Carpob, 1987; McGrath et al., 1990). For this study, depression was defined by the subjects themselves and other terms were
defined by the researcher. The study accepted the women's views and did not attempt to sort out the many and complex influences in their views. There was no attempt to sort out what influence therapy may have already had on participants as it was likely that the participants' views were influenced by the media, family, and friends.

Several assumptions were made in this study. One assumption was that participants would define their own depression. Another assumption was that most of the participants had taken part in some therapy at some point in their lives. The assumption that etiology of women's depression was different from the etiology of men's depression was also stated. Lastly, it was assumed that the young adult women were able to speak for themselves and their words were taken without further verification as it was their perceptions that would yield new information on depression in young adult women.

Qualitative methodology was used in the collection of the data. Feminist principles were incorporated into this methodology, creating a feminist methodology. Data were collected via open-ended, face to face interviews with women who had responded to flyers posted around campus. The focus of the interviews was on the daily life experience of these women. Once collected, the data were transcribed. A second interview was completed with each participant whereby the transcript was reviewed by each participant and additional
data was collected. The data was then analyzed using qualitative analytic procedures. Additional data were gathered through the researcher’s self-reflexive journal and an analysis of available brochures on depression.

This study obtained some new information concerning factors in young women’s lives that may lead to depression that were not previously considered. Those factors seemed to center on the sense of obligation and responsibility that these participants felt toward others. Other factors included violence against women, a poor self-image, lack of support from parents, lack of control, feeling alone, conflicted relationships, and school-related demands. Factors that perhaps aggravated the depression that these participants felt were being forced to overcome their depressive paralysis, putting up a happy facade, physical symptoms, and a lack of therapy.

This study not only yielded new information on depression in young women, but also unique information concerning methodology and the use of feminist and social work theories. In addition, this study initiated discussion on the clinical, research, theoretical, and practice implications from the results of the study. The clinical implications included the need to rethink definitions of mental illness and reconsider the strength of the link between those factors found in this study and depression. Likewise, several research implications emerged from this
study. Implications for research on women and mental illness were discussed as were the uses of qualitative research methodology. The main theoretical implication suggested the use of feminist theory for the study of depression and the notion of caretaking. Finally, the practice implications were extensive and suggested the use of feminist theory with social work practice.

The perspective of the participants yielded not only insight into the etiology of depression in young, adult women but also demonstrated a negative case example. As a negative case example, questions may be raised about the validity of established theories of depression. In short, this study demonstrated the possibility of the social construction of depression in young adult women.
APPENDIX A

FLYER
STUDY IN DEPRESSION

If you are:

- a young woman (age 19-32)
- single (never married)
- without dependents (no children)
- currently enrolled at OSU
- currently feeling depressed (seeking help or not)

I would like to talk with you. I am a doctoral student in Social Work and a licensed social worker doing a study on the experience of depression in the daily lives of young women. This is NOT therapy; it is simply a chance to express yourself, share your experiences with a peer, and contribute to the knowledge of depression that mental health care professionals possess.

Face to face interviews of one to one and a half hours will be conducted. You will be asked to do a second interview and be given a chance to review all "data" (transcripts and notes) in order to provide feedback to the researcher. You will also be asked to sign a consent form prior to participation and fill out a brief biographical survey. Participation is strictly voluntary and you may withdraw at any time. Compensation for your time will be provided. Confidentiality will be assured throughout your participation.

If you are interested or would like more information, please contact Diane at 293-0975 (leave a message on the answering machine so that I may get back to you). You do not have to leave your full name and you do not have to provide any information until you agree to participate.
APPENDIX B

INFORMATION/SCRIPT FOR TELEPHONE INQUIRIES
Information/Script for Telephone Inquiries

This is a study about young women and depression that I am doing for my dissertation. The principal investigator is Dr. Virginia E. Richardson, Professor of Social Work at the College of Social Work here at Ohio State University. I am a third year doctoral student at the College of Social Work. You are being asked to discuss your feelings and thoughts on depression, especially what you perceive to be the source of your depression and how your daily experience influences your feelings. You may also discuss any topic related to your depression. If the discussion becomes too personal or painful for you, you are not required to continue with that topic and you have the right to refuse to answer any question without justification. I am, however, interested in listening to anything that you wish to say about your experiences.

This face to face interview will last approximately one to one and a half hours. The interview will be audiotaped and notes will be taken; this data will be destroyed six years after completion of the dissertation. You will then be asked to do a second one to one and a half hour interview at your convenience and you will be given a chance to review all "data" (transcripts and notes) at a later date in order to provide feedback to the researcher. Again, participation is strictly voluntary and you may withdraw at any time. Compensation for your time will be provided; you will have
the choice of movie pass(es) or a gift certificate per interview valued at approximately five dollars (ten dollars if funding is provided). Confidentiality will be assured on my part throughout your participation. Likewise, anonymity will be assured in the final dissertation/report that is expected to be completed by March 1993. {if you have been solicited through a course, please be advised again that participation or nonparticipation will have no effect on your grade in that class.}

You will be asked to fill out a brief biographical survey and consent forms. In taking part in this research project, you will be contributing to the knowledge that mental health professionals have in assisting young women who are depressed. Please feel free to ask any questions at anytime.
APPENDIX C

INSTRUCTIONS/SCRIPT FOR PARTICIPANTS
Instructions/Script for Participants

This is a study about young women and depression that I am doing for my dissertation. The principal investigator is Dr. Virginia E. Richardson, Professor of Social Work at the College of Social Work here at Ohio State University. I am a third year doctoral student at the College of Social Work. You are being asked to discuss your feelings and thoughts on depression, especially what you perceive to be the source of your depression and how your daily experience influences your feelings. You may also discuss any topic related to your depression. If the discussion becomes too personal or painful for you, you are not required to continue with that topic and you have the right to refuse to answer any question without justification. I am, however, interested in listening to anything that you wish to say about your experiences.

This face to face interview will last approximately one to one and a half hours. The interview will be audiotaped and notes will be taken. You may then be asked to do a second one to one and a half hour interview at your convenience. You will be given a chance to review all "data" (transcripts and notes) at a later date in order to provide feedback to the researcher. (This data will be destroyed six years after completion of the dissertation.) Again, participation is strictly voluntary and you may withdraw at any time. Compensation for your time will be
provided; you will have the choice of movie pass(es) or a gift certificate per interview valued at approximately five dollars (ten dollars if funding is provided). Confidentiality will be assured on my part throughout your participation. Likewise, anonymity will be assured in the final dissertation/report that is expected to be completed by March 1993. {if you have been solicited through a course, please be advised again that participation or non-participation will have no effect on your grade in that class.}

Please be sure that you understand the instructions and consent forms. In taking part in this research project, you will be contributing to the knowledge that mental health professionals have in assisting young women who are depressed. Please feel free to ask any questions at any time and at anytime, you may request a referral to a campus mental health center if you feel that you would like to seek professional help and have not done so already.
APPENDIX D

CONSENT FORM
Participant Consent Form

This study seeks to investigate how young women experience depression. Participants in the study will be interviewed about what they believe contributed to their depression.

Information obtained in the interviews will be confidential; however, it should be noted that confidentiality cannot be absolutely guaranteed since threats of suicide, homicide, or other illegal acts will need to be reported to the proper authorities.

Anonymity will also be assured in the final project report/dissertation. Measures will be taken to prevent information from being linked with a specific respondent by coding all items. The researcher will keep the codes separately from the interview transcripts and other information provided by participants.

The undersigned participant has the right to withdraw from the study at any time or refuse to answer questions without justifying the action. Participation in this study is strictly voluntary.

I hereby authorize Diane Hodge to utilize my interview for use in her dissertation and possible use in journal articles, presentations, instructional purposes, or a book based on the dissertation.

In signing this form, you are also assuring me that you will make no financial claims for use of the material in your interviews. Although member checking will be performed with each participant, the interviews become the property of this researcher. The signature of the participant below signifies that he or she is in agreement with the above statement of conditions of participation for this study.

Signature of Participant ___________________________ Date __________

Principal Investigator: ___________________________ Dr. Virginia E. Richardson
College of Social Work
The Ohio State University

Researcher seeking consent: ___________________________ Diane M. Hodge, MSW, LSW
101 Curl Dr. #416
Columbus, OH 43210
614-293-0975
APPENDIX E

BIOGRAPHICAL SURVEY
Biographical Survey

Please complete this brief biographical questionnaire. You are guaranteed complete anonymity. This information will only be used to describe the general characteristics and backgrounds of those who participate in the study in the final dissertation/report. Thank you.

Name________________________________________
Age________________

Phone______________________________________ (used only to contact participants for subsequent interviews by the researcher)

Marital Status______________________________

Financial Status: Independent Dependent (Parental Support)

If independent, what is your yearly income?

0 - 3500
3550 - 5000
5050 - 6500
6550 - 8000
8050 - 9500
9550 - 11000
over 11050

Place of employment________________________________________

Level of Education: Freshman Sophomore Junior Senior

1st yr Master 2nd yr Master

Doctoral

College/Major________________________________________
APPENDIX F

INTERVIEW SCHEDULE
Focus for Questions for Interviewing

The focus of the interview questions will be on the etiology of depression, including the onset, maintenance (chronic nature), and severity. Various subject areas will be considered; however, interviews will focus on the area that the participant feels is the most relevant to her depression. If time allows, questions concerning help seeking will also be explored.

Biology and developmental factors
This area covers the participant’s interaction with the environment in terms of moods and behaviors and how they relate to interpersonal interactions. Thus, the participants perceptions of their biology and the resulting experiences will form the basis of the relevance of biology to depression. Questions will center on the participant’s description of their experience with PMS, abortion, pregnancy, infertility, and physical illness. In addition, family history (genetic) links will be considered although there is more support for environmental/nurturing factors related to depression. One’s view of growing up "female" will also be explored if relevant to the participant.

Provoking Agents
This area focuses on the negative and positive life events of relevance to the participant’s life and roles, as they perceive it. Questions will consider how experiences are related to depression and also how depression from those experiences change a participant’s perceptions of live in terms of negative mind sets, hopelessness, etc.

Vulnerability
The focus will be on several variables that past literature have found to be related to an individual’s vulnerability to depression. Questions will explore a participant’s "pessimistic style (the sense of power over events or instrumentality and learned helplessness)," strengths (coping), self-esteem, and expressiveness (external social expectations that women respond to other’s needs.)

Relationships
All types of interpersonal relationships have been linked to depression including parental, sibling, work, marital, etc. What is central to all these relationships are their importance, impact, and perhaps loss (breakups, deaths, etc.) These will be explored along with early relationships.
Demographics
Many studies have focused on linking depression with race, class (SES), education levels, number of children, marital status, urban/rural living, etc. All these studies have shown some link but the perspective, importance, and relevance of these factors to the participant will determine whether they will be discussed or not.

Roles
How a participant defines herself may also be relevant to her depression. The number of roles has been looked at but not the importance of these roles, the support for these roles, and the synchronicity of roles with peers.

Violence
Women are more often subjected to violence in their daily lives. Studies have linked violence with helplessness and depression. Areas that will be discussed will include sexual harassment at the work place, victimization in interpersonal relationships (wife battering, incest, etc.) and medical violence (hysterectomies, etc.)

Images of women
The images of women that participants have enhance depression. These images are conveyed through media, socialization, peers, etc. Eating disorders and negative body image have been linked to depression as has overeating.

Seeking help
If recovery responses depend on attributions posited by individuals, when, how, where, etc. women seek help will depend on not only what is available to them, but also why women believe they are depressed. Help seeking also brings up issues of therapy and diagnosis, treatment and drug use, labeling, experiences with professionals, support, etc.
INTERVIEW SCHEDULE

Biological factors:

1. Do you feel that you suffer from PMS and do you feel that it is a factor in your feeling depressed? How so?

2. Have you had a physical illness and do you feel that it is a factor in your feeling depressed? How so?

Developmental factors:

1. Describe your view of growing up female.

2. Did you have female role models? If so, how did they influence you?

3. Tell me about your relationship, past and present, with your mother.

Provoking agents:

1. Have negative things occurred in your life recently? If so, please describe them and how they made you feel.

2. When negative things happen, do you find yourself thinking negatively about other things?

3. Are there positive things that have occurred that affect your feelings of depression?

4. Do you believe that feeling depressed includes feelings of hopelessness or helplessness? If so, please describe these feelings.

Vulnerability factors:

1. Do you feel a sense of power or control over situations? If so, please go into more detail.

2. Do you use coping skills in dealing with depression and if so, what are they or what are your strengths?

3. How would you describe your level of self-esteem? Does it play a factor in your feeling depressed?

4. Do you feel that you care about others much? If so, whom and how much?
Relationship factors:

1. How would you describe your relationship with your parents?

2. How would you describe your relationship with your siblings?

3. How would you describe your relationships at work/school?

4. How would you describe your relationships with significant others?

Demographic factors:

1. Do you feel that your race affects your feelings of depression? If so, how?

2. Do you feel that your SES level affects your feelings of depression? If so, how?

Role factors:

1. Do you feel that you have many roles? If so, how important/significant are these roles to yourself?

2. Do you feel that you get support in your many roles? How much and by whom?

3. Do you feel that you have the same roles and support for those roles as your friends/peer?

Violence factors:

1. Do you feel that you have been sexually harassed and do you feel that it is a factor in your depression?

2. Do you feel victimized in any relationships and do you feel that it is a factor in your depression?

3. Do you feel that you have been the victim of medical violence? If so, what kind and is it a factor in your depression?

Images of women:

1. Do you feel that you have a poor body image and if so, where do you feel this comes from?

2. What images of women do you focus on and why?
Seeking help:

1. When did you decide to seek help for your depressed feelings?

2. How did you come to decide that you had depressed feelings and how did you decide to seek help?
APPENDIX G

PARTICIPANT REVIEW OF TRANSCRIPT
Participant Review of Transcription

Please tell me your level of agreement with the following statements (Strongly Agree, Agree, Undecided, Disagree, or Strongly Disagree) and write any additional comments that you feel are relevant. Thank you again for your cooperation and help in this project.

SD

1. The information that I gave appears to be accurately transcribed.

2. The information now seems to paint a darker picture than is really the case.

3. The information now seems to paint a more upbeat picture than is really the case.

4. There are additional things I'd like to say.

5. Please write any additional comments in the space below:

You may keep or destroy the copy of the transcription if you would like.
LIST OF REFERENCES


Seligman, M. E. P. (1988, August). Why is there so much depression? The waxing of the individual and the waning of the commons. Paper presented to the American Psychological Association, Atlanta, GA.


