WADING THROUGH A PIT
OF MUD

ADOLESCENTS' EXPERIENCE OF

DEPRESSION

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ABSTRACT

Depression is one of the most debilitating experiences to affect both individuals and society in New Zealand. When it is experienced during the formative years of adolescence, its consequences can be devastating. To date, the knowledge of this experience has been inadequate, information being gathered by methods that do not portray the perspectives of young people who have experienced depression. This thesis addresses this inadequacy by presenting an interpretation of young people's experience of clinical depression.

The research process involved my extensive interviewing of 11 young people who met 'The Diagnostic and Statistical Manual Of Psychiatric Disorder Number IV' (DSM-IV, 1994) criteria for a Major Depressive Episode (American Psychiatric Association [APA], 1994, p.317). Their perspectives were sought from their position of recovering from depression. I also interviewed 8 of their caregivers. Both sets of perspectives provided insight into the devastation that young people and their families experience as a result of depression. By exploring the participants' subjective worlds and interpreting this data from a symbolic-interactionist perspective, three key themes emerged. These were their experiences of powerlessness, of feeling stigmatised, and of an altered sense of self.

It was also clear from the analysis that relationships were the key to both positive and negative ways in which the participants experienced depression. The relationships that were important to recovery were those with caregivers, peers, health professionals, and the researcher. Consequently I suggest that enhancing all of the interpersonal relationships identified as important by young people with depression will be integral to healing. These relationships can be re-defined as "therapeutic relationships".
I can't explain it, but I used to tell one of my mates that it felt like I was in a pit of mud and I couldn't get out of it, I had to try and wade through it (interviewee II, in Dunnachie-McNatty, 1995, p.37).

During a previous study I met with a young man who tried to explain what it was like to be depressed. Whilst he believed that he could not explain this experience, his description provided me with a more graphic understanding of what it was like to be depressed than I had received from any text. Why did I want to know what it is like to experience depression?

For the past seven years I have worked with young people experiencing mental health difficulties. I am often asked why I chose to work with young people. On reflection, I believe the reasons are two-fold: the fascination of my own adolescence, and my experience of being a parent to a teenage son. Many of the experiences shared by the young people I see parallel my own and those of my son at this stage of life. These include:

• their struggles in peer relationships;
• their intense need to be loved by parents whilst struggling to achieve independence from them;
• their need to be seen as "cool", yet being frightened by their own behaviour and the risks they take in order to be cool.

Like many of the young people I meet, I found the negotiation of this transitional period a most challenging, yet rewarding experience. To have negotiated this time while experiencing a "clinical" depression is unimaginable to me, and my respect for the young people I meet who are coping with depression is enormous. These thoughts have fueled my interest in wanting to know more about this experience at this life-stage.
The need to "know more" about the experience of depression is also connected to a "best practice" stance I have taken as a clinician. Having made a choice to work with young people experiencing mental health difficulties like depression, I have a responsibility to know what it is that they need. I frequently ask myself how it has happened that I presume to know just what this is. Where did this knowing come from? Some of my knowledge is based in empirical research and some from my experience of working with young people.

Each day at work I have contact with young people who meet medical criteria for a 'Major Depressive Episode' (American Psychiatric Association [APA], 1994, p.317). I employ a combination of psychosocial and biological models of practice (Beaven & Suckling, 1994; Cytryn & McKnew, 1996) to identify specific mental health difficulties described in a diagnostic schedule, ‘The Diagnostic and Statistical Manual Of Psychiatric Disorder Number IV’ [DSM-IV], (American Psychiatric Association [APA], 1994).

The two most common methods of collecting information for DSM-IV (1994) categorisation and to determine illness severity are:
- questionnaires: self-administered inventories which when processed produce scores enabling identification of the severity of depressive features;
- diagnostic interviews: structured face to face contacts by interviewers collecting systematic data that is evaluated using standardised procedures (Fombonne, 1995).

My professional practice requires that I interpret the information collected from the young person, their significant others and past records, and then have a clinical discussion with colleagues. This enables me to decide on a level of severity of depression. This decision helps me to identify a range of interventions aimed at counteracting or minimising the depressive process, and reducing the impact of the depression on the life of the young person (Turner, 1995). These possible interventions are then discussed with the young person.
and their significant others, and if they are comfortable with these suggestions, a "care plan" is established.

A significant amount of my knowledge is made available from the personal accounts of the young people with whom I am in daily contact as they share with me their lives, world views and their experience of depression, an exchange of knowledge in which I am privileged to participate.

If I limited the collection of information from young people to a questionnaire and a structured diagnostic interview, my understanding of their experience would be incomplete and therefore their treatment could be compromised. Thus, through hearing the experiences of young people I am able to extend the information given in a diagnostic schedule such as the DSM-IV (1994). For example, the DSM-IV (1994) identifies that a young person experiencing a Major Depressive Episode is likely to experience difficulties such as sleep disturbance (APA, 1994). By listening to young people describing this experience, I understand how sleep disturbance may influence their ability to concentrate in an educational setting. This information is not available in the DSM-IV (1994).

Another important reason that I chose to undertake this research relates to my interest in how young people experience being labeled as having a mental health difficulty. I have completed academic studies in the department of education at Australian and New Zealand universities although my career has been in nursing. Many of my fellow education students have studied within a paradigm that viewed labeling negatively, yet my career has developed in an environment where diagnosing was the norm. Having access to the philosophies of both disciplines, I have been interested in exploring young people's perspectives of the effects of receiving a medical diagnosis. My suspicion was that a connection existed between the labeling of young people as depressed, and their experience of being discriminated against by society. For example, when young people in school are seen as depressed, their academic performance frequently suffers, but
this is usually tolerated by the school staff. The knowledge that they are depressed and attending a mental health service, however, may be viewed negatively by their peers which may result in their exclusion from peer activities.

As I have become increasingly familiar with a variety of research designs, I have developed an interest in designing research that explores life experiences in depth. Analyses of the meaning people attach to their experience can give me a better understanding of their behaviour and enhance my professional practice whilst allowing their "voices" (see Chapter One) to be heard.

My interest in adolescent depression and my enthusiasm for qualitative methodologies led me to complete a small study in 1995. Hearing the voices of the participants enabled an understanding of their experience. "Wading through a pit of mud" was an example of this.

From this study I discovered new knowledge to assist the recovery of young people experiencing depression. As an example, a positive outcome was the development of a support group at a youth mental health service that was based on the research finding that young people benefited from sharing their experiences with other young people identified with similar difficulties (Dunnachie-McNatty, 1995).

The 1995 study confirmed my belief in the potential to find new information about depression during adolescence by using qualitative methods (see Chapter Two) and encouraged me to conduct a larger study exploring the following question:

- How do young people interpret and describe their experience of medically recognised depression and what can I as a mental health researcher learn from this?
The areas I wanted to explore with the young people were also developed from questions posed by the smaller scale study and included the following:

(i) What (if any) impact has depression had on their lives from the young person's perspective?

(ii) How do young people experiencing depression perceive the role of their supports, both professional and others, in their recovery from depression?

(iii) How do young people describe their experience of negative attitudes that have been reported as being attached to mental health difficulties including depression?

The possible benefits of collecting this information included that:

- by exploring the young person's experience of existing interventions, both medical and non-medical, there would be an opportunity to consider modifications and suggest alternatives to these interventions;
- by exploring the impact of negative attitudes towards young people with mental health difficulties and collecting this information, there would be an opportunity to develop an educational strategy that could be used to counter the negative effects of this stigmatising behaviour.

The specific aims of this thesis are as follows:

(i) To provide an overview of the literature pertaining to adolescence: the developmental and societal factors that promote a vulnerability to mental health difficulties such as depression, and depression as it is experienced by young people (see Chapter One).

(ii) To determine whether depression limits adolescents' voices in society, and prevents their valuable contribution to intervention development (see Chapter One).
(iii) To investigate the value of using qualitative methods to investigate depression (see Chapter Two).

(iv) To identify and explore the emergent themes from the data analysis, consider their implications, and offer suggestions that will expand current intervention strategies (Chapters Three, Four and Five).
CHAPTER ONE: AN OVERVIEW OF THE RELEVANT LITERATURE

1: Introduction to the Literature Overview

The question that will be attended to in this overview is: what is already accepted as knowledge in the area of depression during adolescence? This information provides a basis for me to consider how I might extend the knowledge in this area.

To begin this process, a brief investigation of how adolescents become vulnerable to mental health difficulties such as depression is offered. This is followed by an exploration of the factors that promote a resilience to depression before the presentation of an in-depth discussion of depression during adolescence and some of the psychosocial variables that impact upon this process. I then explore the literature that describes how depression is understood by the medical profession, and how young people say they experience depression. How do these perspectives compare? Are they compatible? Is further research required in either of these areas?

Throughout this thesis, the terms “adolescents” and “young person” are used synonymously. Although the term most frequently used in the literature is adolescence, my own experience has been that adolescents prefer to be referred to as young people.

Another term that is frequently used is “voice”. The socio-political concept of the voice of adolescents is borrowed from Gilligan (1982). I have used this term to refer to how the amount of status a person has in society will influence the extent to which their needs are acknowledged and met.
1.2: Adolescence

1.2.1: A Definition Of Adolescence

The process of defining adolescence is a difficult task, given the many facets that must be considered. It is the very complex nature of adolescence that describes why identifying a cause for the experience of mental health difficulties such as depression has been the focus of considerable research but has produced no one clear answer. It is also why I believe it is important to expand our knowledge by listening to the descriptions of young people and their plethora of experiences.

As an example of the complexities of definition, there is no clear and agreed upon description of when adolescence begins and ends. Whilst the beginning of adolescence is often identified by biological markers such as the onset of puberty, defining when adolescence ends is less clear and has been associated with various sociological markers (Kazdin, 1993). Arnett and Taber (1993) proposed that the period of adolescence can only be recognised by a young person retrospectively on their arrival at adulthood, an idea which supports the need for the recording of personal experience.

A useful definition of adolescence is that of the World Health Organisation Work Group, 1984. This definition attends to both the biological and psychological development of a young person, whilst taking into account the influences of culture and society, and describing the dynamic properties of this life-stage. It is offered as a working definition for the purposes of this thesis:

*Adolescence is the period of transition from childhood to adulthood, and is characterised by efforts to achieve goals related to the expectations of the mainstream culture, and spurts of physical, mental, emotional and social development. The period of adolescence has three cumulative factors. These are biological development (the commencement of puberty to full reproductive maturity), psychological development (the*
cognitive and emotional stages of childhood to those of adulthood) and the emergence from total socio-economic dependence to one of relative independence. It is generally accepted that adolescence is the time of life between the ages of 10 and 19 years, as this time frame is inclusive of the commencement of puberty through to the legal age of majority (Moreillon, 1992, p.420).

1.2.2: Developmental Concepts

Moreillon (1992) suggests that adolescence is a period of transition, and that a young person must complete a number of tasks in order to move into the next life-stage. Failure to cope with these tasks will result in a vulnerability to difficulties such as depression (Caprara & Rutter, 1995; Cicchetti, Toth & Bush, 1988). It is, therefore, necessary to provide information on the developmental concepts that have been reported in the literature pertaining to depression during adolescence (Cicchetti & Schneider-Rosen, 1984). I have used the framework of adolescence as a transitional stage as offered in the definition of adolescence as a basis for this exploration. The concepts that I will explore are:

(i) the development of self and self-esteem;
(ii) the development of social competence;
(iii) achieving individuation; and
(iv) establishing a sexual identity.

(i) The Development of Self and Self-Esteem

The central task of adolescence is to develop an integrated sense of self (Quality of Care and Health Outcomes Committee, National Health and Medical Research Council, 1996).
There have been many theorists who have offered suggestions on how individuals develop a sense of self. Some of the prominent writers include the psychoanalytic theorists:

- Freud; who proposed that identity develops during childhood through a series of conscious and unconscious processes, their function being to establish defined ego boundaries;
- Jung; who proposed that the self develops through conscious interpretations of unconscious processes or archetypes (for a more in-depth discussion, see Abramson, 1990, p.22-60).

As this study focuses on interactional processes, an understanding of the development of self is offered from the perspectives of social researchers. These theorists have focused their studies on the development of the self through a person’s interaction with their environment and the meaning they attach to these interactions (Cooley, 1956; Mead, 1934). An understanding of the terms self-concept and self-esteem is important to the concept of the development of the self. Self-concept refers to how we understand our selves, and self-esteem to the way in which we evaluate our self-concept (Schell & Hall, 1979; Whybrow, 1997).

A review of the literature identifies three constructs that explain the development of self-concept. The first construct introduces ‘self-reflected appraisals’, also known as ‘the looking-glass self perspective’ (Cooley, 1956; in Manis & Meltzer, 1972, p.231). Self-concept develops through interactions with others and is a reflection of others’ appraisals. It results from an awareness of how others evaluate one’s self and the taking on of others’ evaluations as part of a self evaluation. This is believed to affect self-esteem either negatively or positively depending on the evaluation of others (Cooley, 1956; Mead, 1934; Shrauger & Schoeneman [Literature Review], 1979).

The second construct is that of self-fulfilling prophecies. People often behave in ways that are consistent with the expectations of others. When the response they
receive matches their expectation of the interaction, this reinforces their behaviour (Darley & Fazio, 1980; Deux & Major, 1987; Miller & Turnbull, 1986).

The third construct is that of self-esteem based in environmental interaction. The central assumption is that self-concept develops through a person's interaction with their environment which is determined by both positive and negative experiences. For example, because of the adolescent's vulnerable concept of self, negative events such as discrimination, may lead to a lowered self-esteem (Gecas & Schwalbe, 1983; White, 1959).

The relationship between depression, self-concept and self-esteem is clearly outlined in the literature on depression during adolescence and is a central focus in this thesis. The experience of an altered sense of self is clearly articulated in descriptions of self-concept and self-esteem in the accounts of young people's experience of depression (Dunnachie-McNatty, 1995).

(ii) The Development of Social Competence

The task of becoming socially competent underpins adolescent interpersonal development and it is adversely affected by depression (Simons & Miller, 1987).

There are different understandings of social competence which can be attributed to alternate perspectives of culture, gender and human development (Peterson & Leigh, 1990). A general definition of social competence that encompasses the key components identified in the literature on this subject is offered by Waters and Sroufe (1983):

Adaptive functioning in which environmental and personal resources are used to achieve desirable developmental outcomes within interpersonal contexts (Waters & Sroufe; in Peterson & Leigh, 1990, p.99).
The development of social competence has been a focus of considerable study in the area of adolescence as it has been suggested that it may be a major determinant in a young person's transition to adulthood (Adams, 1983; Bandura, 1976; Barber & Thomasing, 1986; Baumrind, 1978; Dornbusch, 1989; Hauser, Powers, Noam & Bowlds, 1987; Hauser, Powers, Noam & Jacobson, 1984; Heaven, 1994; Macoby and Martin, 1983; Olson, 1986; Olson, Russell & Sprenkle, 1983; Peterson and Leigh, 1990; Peterson and Rollins, 1987). The literature is focused in three areas: (a) the skills of social competence, (b) the influence of family on the development of social competence, and (c) the influence of peer interaction on the development of social competence.

(a) The skills of social competence
The literature suggests that the resources required to achieve social competence include positive self-esteem, an internal locus of control, social perspective-taking (social role-taking and empathy), moral development and interpersonal problem solving (Adams, 1983; Baumrind, 1978; Leigh, 1986; Macoby & Martin, 1983; Peterson & Leigh, 1990). The developmental achievements thought to be related to the attainment of these skills include the young person's increasing ability to reason and their improving verbal abilities (Berndt, 1982). The young person is also required to find a balance between sociability and individuality, that is, learning to become sociable whilst accepting the self as unique and different to others (Peterson & Leigh, 1990). Two of the social environments where the development of social competence occurs are the family and school (Bronfenbrenner, 1979). The young person develops the resources of social competence during family and peer interaction.

(b) The influence of family on the development of social competence
The variables of family functioning that facilitate or hinder the development of the resources required for social competence include:
• **Family communication**
  The way in which family members interact with each other and their styles and patterns of communication. Where communication is more frequently clear and direct, the development of social competence is enhanced (Hauser et al., 1984; Hauser et al., 1987; Leigh, 1986).

• **Conflict resolution in families**
  The ways in which families manage to resolve conflict (Forgatch, 1989; Minuchin, 1974; Minuchin, Rosman & Baker, 1978; Wood, 1985). In their 1978 study, Minuchin et al. found that where there were high levels of covert conflict in families, the adolescents presented with poor problem solving strategies and emotional difficulties such as higher levels of aggression. Recent research has extended Minuchin's ideas by focusing on the level of expressed emotion in families as a negative influence on the young person's development of social competence. In families where there are high levels of expressed emotion, it is suggested that there is likely to be an increased presence of mental health difficulties such as depression and behavioural disturbances (Weintraub & Wamboldt, 1996).

• **Family adaptability and cohesion**
  The research by Olson et al. (1983) suggests that moderate family cohesion is necessary for the development of adolescent social competence. Parents need to find a style of parenting that creates a balance between a rigid, overly structured style of functioning, and a chaotic, loosely structured environment of constant change (Barber & Thomasing, 1986; Baumrind, 1978; Macoby & Martin, 1983; Madanes, 1981; Olson, 1986; Olson et al., 1983). Parker, Tupling and Brown (1979) examined the relationship between parental behaviour and attitudes, and mental health difficulties in their children, and suggested that there is a relationship between a parenting style dominated by affectionless control and the development of depressive disorders in adolescence. The findings of this study were re-affirmed by Burbach and Borduin (1986). Conversely, where parents offer less supervision and greater independence, there is an increased opportunity for an identification with anti-social activities such as drug-taking within the

(c) The influence of peer interaction on the development of social competence

Relationships with peers during adolescence also provide an environment for the development of social competence. The peer group offers defined boundaries around what is acceptable and unacceptable behaviour, and through this experience the young person has access to the perspectives of others at the time when their attitudes and values are developing (Hendry, Shucksmith, Love & Glendinning, 1993).

Hendry (1983) describes the process of developing social competence in peer settings as occurring in three phases: observing peers, rehearsing social skills and then trying these out in preparation for adulthood. Membership in peer groups enables the young person to observe their peers for their use of personal and social skills and the social strategies that they employ. Examples of the factors that might be observed are their physical appearance, their use of language, their values and attitudes and their behaviours (Ausubel, Montemayor & Svaian, 1977; Hendry, 1983). Three aspects of social competence that Adams (1983) suggests can be gained through peer group participation are:

• the development of social knowledge as a young person learns the appropriate emotional responses to adopt in a variety of social contexts;
• a growth in the experience of empathy; and:
• a belief in the power of self-initiation (self-confidence to initiate plans in one’s group).

(iii) Achieving Individuation

The development of both a positive sense of self and social competence which occurs through social interaction with family and peers, prepares a young person for another principal task of adolescence, that of individuation.
The process of individuation from the family has been a focus of considerable research and is considered to be one of the most significant tasks of this life-stage (Coleman, 1993; Hill, 1993; Offer & Schonert-Reichl, 1992; Rutter et al., 1976). The function of individuation is to prepare young people for adult relationships. A key factor is the increasing importance placed on the development of peer relationships (Hendry et al., 1993). Few parents of young people (including myself) would deny that the inevitable changes that must be negotiated in the relationship between the young person and their parent(s) during this life-stage are, whilst generally rewarding, quite challenging. Despite this, the literature indicates that excessive conflict between young people and parents occurs infrequently, the majority of young people sharing the beliefs and values of their parents (Coleman, 1993; Heaven, 1994; Hill, 1993; Offer & Schonert-Reichl, 1992).

This thesis will show how the inclusion of the experiences of young people recognised with depression expands the knowledge that is currently available on how depression interferes with the process of individuation (see Chapter Four).

(iv) Establishing a Sexual Identity
The other developmental process cited as creating a potential vulnerability to depression is the development of a sexual identity. Alongside the processes of physical maturation, establishing social competence and developing an identity separate to others is the development of a sexual identity (Preto, 1988; Lewinsohn, Clark & Rohde, 1994). This process occurs through fantasy, experimentation and role-modelling and functions to prepare the young person for adult sexual relationships (Preto, 1988; Kaplan, 1984).

The literature which focuses on sexuality discusses the relationship between homosexuality and depression. The limited number of studies that have focused on this area suggest that there is a positive relationship between adolescent homosexuality, and suicidality and depression (Glass, 1998; Hendlin, 1992). It has been suggested that an increase in suicidality may occur when a young
person with emerging homosexuality is exposed to homophobic attitudes and the associated discrimination (Meyer, 1995).

1.2.3: Perceptions of Adolescents: How the Absence of a ‘Voice’ Creates A Vulnerability to Depression

For decades adolescents have been described in language that is suggestive of turbulence, passion and frivolity (Heaven, 1994). The description of adolescence as a time of “storm and stress” which predominated most of the literature until the early seventies served to promote the notion that significant difficulties were accepted as being normal during adolescence and hence did not warrant investigation (Department of Health, 1992; Heaven, 1994; Lesko, 1996). Whilst being empirically discredited by research completed in the last two decades (Offer & Schonert-Reichl, 1992, p.1003), this understanding remains a popular perception of youth today and perhaps explains why some young people are still viewed negatively by some adults. This may prevent them from having a credible voice in society (see Gilligan, 1982). Examples of how negative views develop are media representations of youth as wild and dangerous beings who steal from the elderly, use drugs indiscriminately, listen to unlikeable music, wear unsightly clothing, treat their parents despicably, and are unstable beings who are prone to experience wild fluctuation in mood (see Rice, 1990, Chapter One). I believe that such views have an alienating effect on young people, and have the potential to promote mental health difficulties such as depression in vulnerable young people.

It has also been argued that the many developmental models and theories that attempt to define “normal” adolescence have contributed to a view of young people being ‘disequilibrated’ (Lesko, 1996, p.454). Lesko refers to adolescence as a time of “becoming” rather than “belonging”, isolating young people by focusing on their ability (or inability) to reach the status of adulthood that society determines as normal (Lesko, 1996).
Other writers have also challenged the notion of defining normal adolescence by using developmental models, contending that the measurement of success has tended to rely upon standardised testing which operates from the assumption that all individuals are on an equal footing to begin with. This fails to take into consideration class, gender or ethnicity as a basis for difference (Connell, 1984; Wyn & White, 1997).

The results of standardised testing are described on a continuum. This automatically disadvantages the ten percent of young people who are represented at either end of the continuum and are frequently labeled as “deviant” or “at risk”. Without a socio-political analysis of their situation, the responsibility for their problems then falls upon the individual or the family and does not take into account other possible explanations such as how systems advantage and disadvantage young people (Connell, 1984). Connell contends that if we continue to use traditional models as the basis for understanding adolescent development, we must take responsibility for the marginalising effects that may result from this.

1.2.4: Socio-Political and Cultural Factors

Any understanding of what makes young people vulnerable to mental health difficulties such as depression must take into account the:
(i) socio-political; and:
(ii) cultural factors that have created a context in which their mental health difficulties have developed (Dornbusch, 1989).

(i) Socio-Political Factors

In addition to the adjustments that are required for a young person to successfully manage their transition to adulthood, there are other recent social changes that have been implicated as having added to the demands young people will encounter during their transition to adulthood. For example, changes to family structures over recent decades which include increasing divorce rates, single parent families and step or blended families have been cited as creating a
different society where children and young people are required to adjust to the associated stresses. Examples include coping with day-care, moving between parents' homes and establishing relationships with parents' new partners (Emery & Laumann-Billings, 1998; Moreillon, 1992).

Marked changes in family structures in New Zealand have occurred. Between 1966 and 1996 the divorce rate rose from 3.5 to 13 divorces per 1000 marriages (Horwood, 1999). Between 1981 and 1986, there was a 21 percent growth in single-parent families, by 1986 one in five families being of this nature. This trend has continued. Other changes include an increase in reconstituted families, and an increase in couples delaying child-birth or remaining childless with the numbers of children per family decreasing (Davidson, 1990). The number of women working rose 22.4 percent between 1991 and 1996, increasing the need for day-care (Horwood, 1999).

Other local stresses include the increase in illicit drug use (Nightingale and Mulder, 1992) and the associated peer-pressure on young people to use drugs, diseases such as HIV and hepatitis (White, 1991) and the associated demands for changing sexual practices to more safe methods.

Economic factors such as decreasing employment opportunities and reducing access to governmental assistance (for example the 1998 changes to the New Zealand youth benefit scheme) have resultant societal effects. These include an increase in the number of people living at or below the poverty mark with thirty-two percent of New Zealand children living in households where the income is below sixty percent of the median (Child Protection Trust Advocacy Committee, 1996).

Governments facing rising unemployment rates may choose to raise the school leaving age to conceal statistics that might potentially disadvantage their political popularity (Kaplan, 1984), whilst many schools are unable to provide the emotional support that is required for a young person to succeed in this
environment (Fombonne, 1995). The rapid technological change that has been witnessed in the last three decades has also had an impact on employment, creating further reductions in job opportunities for young people and demanding ever increasing levels of qualification in order to be competitive in the marketplace (Heaven, 1994; Crockett, 1996). The resultant continued financial dependence on parents will mean that young people leave home later, effectively lengthening adolescence as leaving home has been one of the sociological markers defining when adolescence ends (Kazdin, 1993).

Legal factors add another dimension to the complex process of negotiating adolescence. An ambiguity young people face is the conflicting messages attached to their attainment of legal rights. New Zealand examples are a young person’s right to access a termination of pregnancy procedure without their parents’ knowledge or consent, whilst parental consent is required for most other activities until age 16 or 18. Young people have the right to vote at 18 years of age, can drive at 15 years, yet until recently were unable to enter a licensed premise without an accompanying parent before 20 years of age. This parental and governmental control results in a sense of powerlessness (White, 1991).

(ii) Cultural Factors
An understanding of adolescent development would be incomplete without the inclusion of a cultural perspective and how cultural factors may be implicated in the development of depression in young people. This has been a significant omission from past research (Wyn & White, 1997).

The two factors that have been addressed in the literature are how Western and non-Western cultures understand the entry and exit points that define adolescence, and the resultant effects of the continuing infiltration of Western ideologies on non-Western cultures (Arnett and Tabor, 1993). For example there may be different cultural perspectives on when adolescence begins and ends (Arnett & Taber, 1993). For many non-Western cultures, the entry and exits from adolescence are marked by rites-of-passage. As an example, the Navajo
North American Indian celebrate menarche by the young woman adopting the persona of "Changing Woman", a mythical being representing fertility and nature (Kaplan, 1984, p.240). Other non-Western cultures mark the end of adolescence by a ceremony such as marriage, often at a specific age.

In Western cultures where the focus is on independence and individualism, the entry to adulthood is marked by an ability to be emotionally and financially independent, living away from parents (Kazdin, 1993). The age of marriage may also be determined by these attributes and is not fixed. In New Zealand, for example, marriage is occurring later; between 1971 and 1996 the average age of women entering their first marriage rose from 21.7 to 27.1 (Horwood, 1999).

Western influences are the catalyst for changing perspectives of the meaning of culture within non-Western cultures. Arnett and Taber (1993) describe a general world-wide trend of changing patterns of socialisation that affect the traditional timings of role transitions. This results in a change from the previously clear cultural descriptions of when adolescence ends. Examples of this include the Morrocans and the Inuit who have experienced changes in recent decades that reflect what Arnett and Taber (1993) describe as being related to the increase in access to ideals of Western cultures through music and media. The impact of such influences include extending the time spent with peers and delaying the age for marriage, hence altering the previously culturally determined departure from adolescence.

In New Zealand imposing a model of adolescence developed by Europeans fails to acknowledge that for traditional Maori there was no language equivalent for adolescence, and there is continued debate amongst Maori as to the value of recognising adolescence (Ministry of Health, 1996). Through changes such as urbanisation, young Maori have experienced an isolation from their culture. This has resulted in such difficulties as educational disadvantage, young Maori attending New Zealand schools that have been traditionally designed for students of the dominant Pakeha culture (Sultana, 1989). Sultana reported that
approximately 49 percent of Maori left school to face unemployment, and only five percent entered professional work. The psychological impact of these factors include the high rates of mental health difficulties and substance problems that young Maori experience (Ministry of Health, 1996; Pomare, Keefe-Ormsby, Ormsby, Pearce, Reid, Robson, Watene-Haydon, 1995).

1.2.5: Exploring the Concept of Resilience

It is important to acknowledge that by far the majority of young people manage the transition of adolescence to adulthood well, and the 20 percent of young people who present with psychological difficulties during adolescence is comparable with the rate present during other life-stages including adulthood (Offer & Schonert-Reichl, 1992). As in other life-stages, some adolescents are more resilient to stressful events than others.

A review of the literature on childhood resiliency to adversity indicates a number of biological and environmental factors that may explain why some young people overcome early disadvantage (Baldwin, Baldwin & Cole, 1982; Bradley, Whiteside, Mundfrom, Casey, Kelleher & Pope, 1994; Fergusson & Lynskey, 1996; Gottlieb, 1991; Greenwood, 1989; Gribble, Cohen, Wyman, Work, Wannon & Raoof, 1993; Herrenkohl, Herrenkohl & Egolf, 1994; Lerner, 1982; Patterson, 1982; Parker et al, 1979; Seifer, Sameroff, Baldwin & Baldwin, 1992; Werner, 1989). Factors that have been identified include interests or attachments outside of the family, possibly being female (although the research is equivocal in this area), and having a relaxed temperament (Werner, 1989).

The nature of relationships with parents as a protective factor in the study of childhood resiliency to adversity is another area that has been the focus of considerable research. Studies in the 1970’s and 1980’s established positive relationships between such factors as competence at school, intelligence and psychosocial functioning with well functioning families measured by high levels of interaction, consistent parenting and positive parent-child relationships (Baldwin et al., 1982; Greenwood, 1989; Parker et al., 1979). In a longitudinal
study, Seifer et al. (1992) studied a group of children to age 13 and suggested that several factors including maternal interaction were considered protective. Other studies have suggested that the nature of a relationship with at least one parent may be a protective factor. Factors that were suggested as being protective included a warm style of interacting, and relationships that were perceived as supportive (Bradley et al., 1994; Gribble et al., 1993; Herrenkohl et al., 1994).

In the Christchurch Health and Development Study (Fergusson & Lynskey, 1996) resiliency to childhood adversity was examined in a birth cohort of 1000 children, studied to 18 years of age. The results of this research included that at 16 years, resilient adolescents (described as being able to cope with external pressures), were recognised as having greater intelligence, lower novelty seeking behaviours and fewer associations with anti-social peers. Whilst unable to make any conclusions about the role of parents and resiliency in their offspring, the researchers suggested it was possible that parental factors would be mediated through these three factors (Fergusson & Lynskey, 1996).

1.2.6: Concluding Comments on Adolescence
When we consider the pressures and the transitions that are necessary to negotiate between the end of childhood and the beginning of young adulthood, it is not surprising that there is a degree of variance in the rate that young people complete the developmental tasks that mark their arrival at young adulthood. The broader social context in which young people develop has become increasingly complex, evidenced by the weakening of traditional support systems alongside increasing changes in family structures (Fombonne, 1995). Despite this, most young people enter their adult years without significant adjustment difficulties when compared with other age groups negotiating life-stages (Offer and Schonert-Reichl, 1992). This provides an understanding of a young person’s considerable resilience to adversity.
The focus of this study is on young people for whom the transitional process has been interrupted by depression. By reviewing the complexities of the experience of adolescence reported in the literature on depression, an understanding of the potential devastation that may occur when adolescent development is complicated by depression is possible.

1.3: Depression

1.3.1: A Definition of Depression

Depression is a commonly used expression that is attached to feelings of grief and sadness, both being a part of a normal human experience (Harrington, 1993). At some point along the mood continuum, feelings of grief and sadness move into the realm of clinical depression.

There are differing opinions about when a normal mood fluctuation can be categorised as clinical depression (Grove & Andreason, 1992). In medicine, two diagnostic schedules have been developed that are used as guidelines to recognise mental illness and attempt to define clinical depression. These two schedules are ‘The International Classification of Diseases Number 10’, (World Health Organisation, 1990), and ‘The Diagnostic and Statistical Manual Of Psychiatric Disorder Number IV’ [DSM-IV], (American Psychiatric Association [APA], 1994). The DSM-IV (1994) is the schedule most commonly used by mental health professionals in New Zealand. A category described in the DSM-IV (1994) is ‘Major Depressive Disorder’, which is characterised by one or more ‘Major Depressive Episodes’ (APA, 1994, p.339). This study focuses on young people who have been medically diagnosed as being depressed in an attempt to understand how they have interpreted the process of medical diagnosis and treatment, and the impact of depression on their lives. The category of depression used in this study was ‘Major Depressive Episode’, defined as follows:

A Major Depressive Episode is characterised by a period of at least 2 weeks during which there is depressed...
mood or the loss of interest or pleasure in nearly all activities. In children and adolescents the mood may be irritable rather than sad. The individual must also experience at least four additional symptoms drawn from a list that includes changes in appetite or weight, sleep, and psychomotor activity; decreased energy; feelings of worthlessness, or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thoughts of death or suicidal ideation, plans or attempts. To count towards a Major Depressive Episode, a symptom must also have clearly worsened compared with the person’s pre-episode status. The symptoms must persist for most of the day, nearly every day, for at least two consecutive weeks. The episode must be accompanied by clinically significant distress or impairment in social, occupational, or other areas of functioning. For some individuals with milder episodes, functioning may appear normal, but requires markedly more effort (APA, 1994, p.320).

The other category describing low mood also described in the DSM-IV is Dysthymic Disorder:

Dysthymic Disorder is characterised by at least 2 years of depressed mood on more days than not, accompanied by additional depressive symptoms that do not meet criteria for a Major Depressive Episode (APA, 1994, p.317).

The difference between the two categories is determined by the individual’s description of the severity of the “symptoms”. For example, the term ‘Dysthymic Disorder’ would be used if less than five of the described features are present, or they have not been in existence for more than the two week period. Whilst a Dysthymic Disorder is characterised by long-term ongoing mood difficulties, the experience of low mood is much less severe and less
incapacitating than a ‘Major Depressive Episode’ which will result in a significant restriction to a person’s ability to continue with their usual functioning. However, it is important to note that approximately 70 percent of people with a diagnosis of early onset ‘Dysthymic Disorder’ are later diagnosed as having a ‘Major Depressive Disorder’ (Birmaher, Ryan, Williamson, Brent, Kaufman, Dahl, Perel & Nelson, 1996).

Another significant mental health difficulty outlined in the DSM-IV section on mood disorder is ‘Bipolar Mood Disorder’ where mania is also a part of the presentation (APA, 1994, p.318).

This study addresses the impact of depression by gaining the young people’s interpretation of what has been medically recognised as significant symptomatology and the resultant effect on their experience of life. Young people with a single diagnosis of ‘Dysthymic Disorder’ are, therefore, not included in this study. Young people with diagnosed ‘Bipolar Mood Disorder’ are also excluded as the complexities of their difficulties were considered to be beyond the scope of this research. Future studies including these groups is recommended.

1.3.2: The Medicalisation of Adolescent Depression and The Effects of Labeling

Concerns have been expressed about the use of schedules such as the DSM-IV (1994) to describe depression during adolescence. These relate to the difficulties in developing diagnostic guidelines that reflect the presentation of mental health difficulties at a wide range of ages.

Attempting to define specific features of depression in children and adolescents was the domain of researchers during the 1970’s (Weinberg, Rutman, Sullivan, Pencik & Dietz, 1973). It was clear that whilst features of depression that had been defined for adults were also present in young people who were considered to be depressed, the presentation of these features often differed when observed
in young people. An example is the sleep disturbance experienced during depression. For adults this may be insomnia and associated sleep disruption. For young people sleep disturbance often presents as hypersomnia, with sleep exceeding 15 hours per day not being uncommon. Despite these differences, it is considered to be diagnostically correct to use the diagnostic schedules developed to describe mental health difficulties across the spectrum of all ages, in order to identify core criteria for mental health difficulties during adolescence (Kazdin, 1989). In fact, whilst acknowledging that the presentation of depression may be different for young people when compared to adults, there are no alternate categories offered that reflect the developmental differences between young people and adults.

Another difficulty pertains to the way in which the DSM-IV (1994) is used. Whilst initially developed to provide diagnostic guidelines, the schedule has been more recently used for a range of economically-driven activities such as the identification of eligibility for health insurance rebates as the concept of "managed care" is embraced by many Western countries (Crowe, 1998; Yapko, 1997). As an example, with the introduction of the Medicare system of health delivery in the United States, the amount of remuneration for psychiatric treatment is dependent upon a specific DSM-IV (1994) diagnosis. The diagnosis will describe what services an individual will be offered. Such a system does not account for the unique characteristics of individuals and their responses to the prescribed services offered. Additionally, it has been suggested that there may be an incentive for providers to supply a higher fee-paying diagnosis, opening the door to abuses of individuals and society (Crowe, 1998).

Such uses undermine the schedule's credibility by encouraging what has been referred to as the phenomenon of "psychiatry by numbers" where institutions such as health care insurance companies will demand a diagnosis before a rebate is offered. In this system it is possible that clinicians will adopt an approach of identifying specific mental health difficulties in order to satisfy the necessary criteria for a rebate. Whilst this statement is unreferenced, I witnessed such
practices when employed in a private psychiatric hospital in Melbourne, Australia. Such approaches to psychiatry are linked to the push to identify depression as a biologically driven illness that is treated by medical means (medication) and removing access to adjunct psychotherapeutic treatments (Yapko, 1997). As Yapko suggests:

*The idea that depression is a clear cut illness, caused by a chemical imbalance that can be cleared up with a daily dose of Prozac or Zoloft, now threatens to become a widely accepted clinical mantra and a popular shibboleth, repeated in best selling books, mass circulation periodicals and morning TV talk shows...*

*Depression is also among the most medicalised of psychiatric diagnoses; indeed family doctors, not psychiatrists, write up to 70 percent of antidepressant prescriptions with a wide array of medications to choose (Yapko, 1997, p.44).*

The medicalisation of depression and the tendency to reduce an understanding of depression to a simplistic description fails to articulate the impact of the difficulties on a young person's functioning. Expanding on my earlier example of sleep-disturbance and the experience of fatigue, whilst listing features such as poor concentration, the schedule cannot describe the personal frustration and distress caused by the impact of depression on school performance. It is clear to me that a study that uses the descriptions of young people's experience of depression may add depth and breadth to what we know about depression; knowledge that has been developed for the most part by using quantitative methods.

*Diagnostic Schedules and the Effects of Labeling*

Another area that must be addressed in the discussion of the use of diagnostic schedules to describe mental health difficulties relates to the reported effects of labeling, or stigmatisation. Throughout the 20th century writers such as Goffman (1959), Gove (1975), Laing (1967), Szasz (1961), and Tannenbaum
have focused on the effects of labeling. Tannenbaum succinctly describes how a labeling process impacts upon an individual, in this case, a prisoner:

> The process of making the criminal is a process of tagging, defining, identifying, segregating, describing, emphasising, making conscious and self-conscious; it becomes a way of stimulating, suggesting, emphasising, and evoking the very traits that are complained of (Tannenbaum, in Gove, 1975, p.3).

Gove (1975, p.4) described two types of deviance: primary deviance where a behaviour is labeled as deviant, and secondary deviance where behaviour occurs because of the deviant label. As the dominant group decide who the deviant group may be, those on the margin of society who hold the least power, influence, voice and resources are therefore most likely to be defined as deviant. Tannenbaum (1938) suggests that once a person has been labeled as deviant (such as being told that they have a mental disorder), they are placed in a special position and given a special role. These positions and roles become self-fulfilling prophecies when people who are outside of the deviant category change their behaviour towards them. Roles become stigmatised as these people are categorised together, for example, people residing together in mental health services. This results in the formation of a sub-culture which combines a similar world view with shared activity (Tannenbaum in Gove, 1975, p.4).

An alternate view of labeling is that it can have positive consequences. People considered deviant will be grouped as a sub-culture away from others in an environment where rehabilitation can occur. This view is therefore concerned with the transformation of identity, role and behaviour (Gove, 1975).

However, labeling theorists argue that while most deviant behaviour is transitory, the act of labeling creates an impression for other people that the deviant status is permanent (Goffman, 1959; Laing, 1967; Tannenbaum, 1938). The effect of such an image influences the person with the label, resulting in
psychological difficulties such as reduced self-confidence and demotivation, whilst increasing their susceptibility to mental health difficulties and some physical illnesses over time (Crocker & Major, 1989). This process is called stigmatisation. Crocker and Major (1989) define stigmatisation as a concept where negative attitudes or beliefs are held towards members of a specific social category. People within these categories are denied a full and equal social standing compared with others in society, and are perceived as “disgraceful”, “immoral” or “sick” (Crocker & Major, 1989, p.611). Discrimination towards these people may lead to economic and interpersonal disadvantage. Such social categories may include people with coloured skin, people seen as unattractive to the dominant group, people with physical deformities and people with intellectual or mental health difficulties, such as the young people in this study who have been medically diagnosed as being depressed. An exploration of how young people experiencing depression have perceived stigmatisation will add to what is currently available in existing literature.

1.4: Depression During Adolescence

1.4.1: Models that Explain Depression During Adolescence

Several models developed from understandings of normal adolescence suggest how depression develops. They include:

(i) psychoanalytical;
(ii) cognitive;
(iii) behavioural;
(iv) cognitive-behavioural;
(v) biological;
(vi) psychosocial; and
(vii) a multi-faceted model.

(i) The Psychoanalytic Model
The psychoanalytic theory of normal adolescent development advanced from the theories of Freud, Erickson and Blos (Coleman, 1993) and focused on the
psychosocial development of the young person. Central to this viewpoint are three fundamental constructs. The first of these is the vulnerability of personality resulting from a sharp increase of instincts or drives at puberty. Secondly, psychoanalysts believe that maladaptive behaviour results from immature ego-systems and poorly developed psychological defenses causing young people to use poorly developed defense mechanisms to manage difficult feelings. The third construct is individuation from parents where young people form relationships with their peers outside of their families before moving into couple relationships (Coleman, 1993).

A delay until the early 1970's in the recognition of depression as an entity present during childhood and early adolescence, has been attributed in part to the psychoanalytic theorists (Reynolds & Johnston, 1994). The psychoanalytic belief that depression could not occur during these life-stages owing to immature superego systems prevented an exploration of this possibility. This thinking was challenged by the psychoanalyst Bibring in the 1950's who proposed the theory of 'ego helplessness' (Bemporad, 1994, p.82) which would interrupt a development of self and could occur at any point of ego development. This theoretical shift in thinking made it conceptually possible for children and adolescents to experience depression.

In the 1960's psychodynamic theorists studying depression during the adolescent years focused on the relationship between loss, aggression, defense mechanisms and individuation (in Poznanski & Zrull, 1970). This thinking was challenged once again in the mid-1960's with the introduction of the antidepressant medications, strengthening the position of biomedical researchers (in Bemporad, 1994). The relationship between loss, individuation and depression will be explored in Chapter Four.

(ii) The Cognitive Model
The psychologist, Jean Piaget (Heaven, 1994) described a developmental model which focuses on the cognitive development of children and adolescents as being
the principal determinant of their behaviour. Cognitive development is thought
to occur in stages. The stages determining adolescent behaviour are the periods
of concrete thinking (seven to eleven years) through to formal operational
thought (twelve years to adulthood). On attaining formal operational thought,
they will be capable of logical and abstract thinking and decision making. Until
this time the mainstream view was that young people were irrational,
unpredictable, and unreasonable, and therefore potentially unstable and
vulnerable to such difficulties as depression (Inhelder & Piaget, 1958; Lesko,
1996). This thinking possibly fueled the negative public view of adolescents.
By the 1970's Piaget began to question his own philosophy recognising that not
all adults demonstrated their capacity for logical thought and decision making at
all times (Keating, 1990). Despite this, Piaget's theory is still lauded as one of
the most important theories of human development (Heaven, 1994).

(iii) The Behavioural Models
The learning models are based on the ideas of the Enlightenment writer John
Locke who believed that behaviour develops from the child interacting with their
environment (Heaven, 1994). This thinking forms the basis of the behavioural
models, with principal theorists including Pavlov and Skinner who developed
the theory of the conditioned response (Heaven 1994). The central construct of
the behavioural model is reinforcement. Acceptable behaviours are reinforced
when they are rewarded. If other behaviours do not gain peer approval, they are
unlikely to be repeated, and when unacceptable behaviours are punished this is
also likely to decrease their frequency (Heaven, 1994).

Behavioural theory ignores a capacity for human internal states such as feelings
or innate drives which supporters of the psychoanalytic model would argue
potentially influence or even determine behaviour. Behavioral theorists such as
Lewinsohn asserted that depression is caused by changes in reinforcement, either
positive or negative, or varying amounts of both (Lewinsohn, Biglan & Zeiss,
1976). They also believed that depressed people are less able to elicit
reinforcing behaviours from others, and that they are less able to exercise social
skills. These behaviours are thought to set up a cycle of responses that further reinforce the depressed person’s negative view of themself.

(iv) **Cognitive-Behavioural Models**
The literature describes other models that are based in both cognitive and behavioural theory. Two important models in this area are: Beck’s model of ‘cognitive distortion’; and Seligman’s model of ‘learned helplessness’ (See Kaslow, Brown & Mee, 1994, p.97).

Beck’s model of cognitive distortion suggests that people develop negative generalisations about events and view themselves in relation to others in negative ways. Seligman’s model is based on an assumption that we learn negative patterns of responding to events, and over time the negative response becomes generalised to other situations. Both models are concerned with personal beliefs of failure and non-achievement that are connected with the experience of depression (Kaslow, Brown & Mee, 1994). Both remain important models from which intervention therapies for depression have been developed.

(v) **The Biological Model**
Biological theorists believe that human development is biologically determined. During adolescence physical development includes significant endocrine changes that prepare the body for reproductivity. The study of puberty is complex in that the physical changes associated with puberty occur over a prolonged period. The commencement of puberty is generally earlier in females than males, and there is evidence to suggest that puberty has occurred at an earlier age for both males and females in every decade of this century (Coleman, 1993; Fombonne, 1995). Dryfoos (1990) claims that young women reach menarche four years earlier now than they did last century. This has been attributed to a number of factors which include improved nutrition and health care (Etaugh & Rathus, 1995).
The perspective that young people are casualties of increasing levels of hormones at puberty enhances a mainstream view of young people as unbalanced. Recent literature suggests that the impact of increasing amounts of the sex hormones at puberty has a minimal effect on adolescent behaviour (Hill, 1993; Fombonne, 1995; Lesko, 1996).

Biological theorists have suggested that depression results from imbalances of neurotransmitters, with noradrenalin, serotonin and acetylcholine being the foci of the research of the last two decades (Glod, 1996; Kazdin, 1989). The most recent research suggests that decreases in serotonin are implicated in depression, this neurotransmitter affecting mood and behaviour (Mohr, 1998). Such beliefs underpin the development of the antidepressant medications as a significant treatment for depression.

**A Psychosocial Model**

A psychosocial model explaining depression focuses on events that have occurred during a young person’s life that have been linked with the development of depression.

Studies of the impact of such life events as early separation from a parent by death or divorce, serious illness often of a continuing nature, and sexual or physical abuse have been shown to be associated to depression (Rheinherz, Stewart-Berghauer, Pakis, Frost, Moeykens & Holmes, 1989; Roy, 1985). The most significant literature found pertained to (a) familial factors and (b) sexual abuse.

**(a) Familial factors**

Where there is a family history of depressive disorder, most studies have found that off-spring have a 50 percent chance of developing mental illness, although the exact reason for this is unclear (Ries Merikangas & Angst, 1995). Studies of families where parents have been depressed have found that the family environment is a significant factor in the presence of depressive disorder in adolescents (Hops, 1992; Peterson, Compas, Brooks-Gunn, Stemmler, Ey, &
Grant, 1993; Rutter, 1989). Factors such as abuse, parental discord, divorce, rejection and inattention have been reported as present where the parents are depressed (Rutter, 1989). Where parents are experiencing depression, they are reported to be punitive and inconsistent in their parenting styles (Cohen, Brook, Cohen, Veliz & Garcia, 1990; Holmes & Robins, 1988). The family environment as a risk factor for the development of depression during childhood was extensively investigated in the Zurich cohort study (Angst, Merikangas, Scheidegger & Wiki, 1990). They found that significant predictors of depression were mental health difficulties in first degree relatives, neglect, and interpersonal conflict in parents. No one specific type of parental mental health difficulty was found to be more of a predictor in the development of depressive disorder than another (Merikangas, Prusoff, & Weissman, 1988). This suggests that the presence of parental mental health difficulties is likely to impact upon a family environment in a characteristic way that becomes a risk factor for the development of difficulties such as depression in the offspring (McGuffin & Bebbington, 1988).

The focus of recent research has moved away from an attention to specific family events. Instead, the unique characteristics of each family member are considered to be fundamental to an understanding of that person's susceptibility to stress caused by life events affecting families (Ries et al., 1995).

(b) Sexual abuse

Of the many researched life-events that are reported in the literature pertaining to depression, there has been a significant focus in recent years on sexual abuse. A review of the research in this area by Beitchman, Zucher, Hood, & DaCoster (1991) suggests that there is a positive relationship between sexual abuse as a child and depression during adolescence, alongside other mental health difficulties such as anxiety and drug and alcohol abuse.

(c) Local factors

As a final comment on psychosocial factors, in their New Zealand research, Horwood and Fergusson (1998) agreed with other researchers who had identified
a relationship between psychosocial factors and depression. Horwood and Fergusson (1998) listed these as:

...social disadvantage, family dysfunction, adverse childhood experiences, impaired parenting and parental psychopathology, adverse peer relations, compromised school achievement and previous mental health problems (Horwood & Fergusson, 1998, p.24).

(vii) The Multi-faceted Model
The current thinking about the development of depression is moving away from the notion that any one factor may be identified in a cause and effect relationship and towards a more complex interplay of biological and environmental factors (Kendler, Neale, Kessler, Heath, & Eaves, 1992; Watkins, 1995). A young person's predisposition to depression must be seen in a multi-modal context. Depression is most likely to occur in the context of psychosocial stresses such as those presented throughout this review, in young people biologically predisposed to depression (Emery, 1988; Watkins, 1995).

When studies are undertaken that seek to explain the significance of psychosocial events, there needs to be a consideration of the contexts in which these events have occurred. For example the specific characteristics of the individuals involved such as their personalities and temperament and interactional styles, alongside socio-political and cultural factors (Ries et al., 1995). Qualitative studies, where the experiences of young people with depression are interpreted, are likely to provide further information on the contexts of events and their contribution to experiences of depression.
1.4.2: The Incidence of Depression During Adolescence

The literature that describes the incidence of depression is based on studies that use the diagnostic schedules to determine the presence or absence of mental illness.

In their literature review, Horwood and Fergusson (1998) established that the rates of mental disorder (meeting the criteria for DSM-IV [1994] diagnosis) in young people were in the vicinity of 40 percent. This was consistent with their findings from their New Zealand study of a birth cohort of 1000 Christchurch born children aged between 16 and 18 years (Horwood & Fergusson, 1998). Their review included studies from the USA, Canada, the Netherlands and South America. In their breakdown of the types of disorders, Horwood and Fergusson (1998) found that 7.1 percent of their total sample at age 18 years were experiencing a Major Depressive Episode, and that 22.1 percent of their sample had met criteria for this disorder between the ages of 16 and 18. Rates of depression continue to increase each decade of this century (Coryell, Endicott & Keller, 1992; Klerman, 1988; Klerman & Weissman, 1989; Ryan et al., 1992). The literature suggests that until the last decade the rate at pre-pubescence has been equal for boys and girls, and by mid-adolescence the rate for girls double that for boys (Fombonne, 1995; Todd & Geller, 1995; Watkins, 1995). There now appears to be a narrowing of the gap between young men and women at mid-adolescence and overall increasing rates of depression during this life-stage (Fombonne, 1995).

Other notable information includes the suggestions that experiencing a first episode of depression increases the chances of experiencing a further episode (Kovacs & Gatsonis, 1989; Watkins, 1995), and that where depression recurs there is a greater likelihood of incomplete recovery (Coryell, Schaftner, Keller, Endicott, Maser & Klerman, 1993; Paykel, 1994; Pyne, Patterson, Kaplan, Gillan, Koch, & Grant, 1997). The seriousness and pervasive effects of depression on people’s lives supports my view that research which extends the
knowledge in this area is vital to increase our understanding and encourage more effective treatment methods.

1.4.3: The Consequences Of Depression During Adolescence

(i) For Individuals

The literature suggests that the course of depression in adolescence differs to that in adults in that periods of improved functioning are interspersed with intense periods of depression (Angst et al., 1990).

The duration of an episode of depression varies between individuals and across studies. In one study the duration was up to one month for 25 percent of cases and up to 3 months for 50 percent of cases. A further 25 percent of cases extended beyond a year (Atkinson, Atkinson, Smith & Hildgard, 1987, p.503). In a longitudinal study of 100 young people age 8 to 13, Kovacs and Gatsonis (1989) reported that the median duration of an initial episode of depression was 9.5 months. In a 10 year follow-up study of 258 people diagnosed with depression, the duration of recurrent episodes averaged 4 months (Soloman et al., 1997). Other findings suggest that following recovery from depression young people are at greater risk of experiencing psychosocial difficulties. Examples are reduced capacity for intimacy, a loss of social supports, and increased use of alcohol and drugs (Fleming, Boyle & Offord, 1993; Kandel & Davies, 1986; Ries, Merikangas & Angst, 1995). A further significant finding suggests that the earlier the onset of depression during adolescence, the more the likelihood of severe consequences (Rohde, Lewinsohn & Seeley, 1994). The most serious outcome of depression is suicide (Kovacs & Puig-Antich, 1991; Meeks, 1986; Ries, Merikangas & Angst, 1995). Horwood and Fergusson (1998) reported that of their sample of 1000 young people, 55 had attempted and two had completed suicide by 18 years of age. Seventy-four percent of the 55 young people met diagnostic criteria for depression before age 18, and 93 percent had at least one diagnosable mental health difficulty.
Researchers who have studied suicide during adolescence have suggested that it is common for young people who complete suicide to often have two or three mental health difficulties at the time of their death. These may include depression, substance use and conduct problems (Canterbury Suicide Project, 1994). Acknowledging that suicidal behaviour is common amongst young people experiencing depression was of specific importance when designing my research. It was important to use a design that would ensure the safety of the participants during their potential periods of suicidality. This concern is more fully discussed in the methodology chapter.

Other consequences of depression include psychosocial problems, predominantly relationship difficulties in adults who have experienced depression in their adolescence. It has been suggested that these result from the impact of depression ‘on the development of educational, social and occupational skills’ (Ries, Merikangas & Angst, 1995, p.137). Another suggestion by Sherbourne, Hays & Wells (1995) from their North American study of 604 people with depression was that the outcome following depression will be influenced by a number of psychosocial factors. These included employment, lowered use of alcohol and other drugs, and active coping strategies in addition to good levels of social support, non-avoidant personality styles and fewer comorbid conditions. Despite the fact that the sample group in this research were adults, these findings are similar to Horwood and Fergusson’s New Zealand findings. They suggested that whilst the presence of these factors could be described as protective, the alternate for each would be viewed as risk factors for depression during adolescence (Horwood & Fergusson, 1998).

(ii) For Society
Depression commonly occurs during the important periods of development and personal productivity (Pyne et al., 1997). Therefore, as increasing numbers of individuals experience depression a potential for negative effects on and within society is created. This highlights the importance of developing a strategy which
will address the incidence and consequences of depression at all life-stages and of reviewing existing and developing new interventions.

1.4.4: The Adolescents’ Experience of Depression

I will now answer the question posed earlier in this thesis: what do we know about the experience of depression during adolescence? To do this I will offer a review of the literature that describes how depression is experienced. This includes the discussion from medical texts, and information from the personal accounts of people who have experienced depression. This will highlight my belief that the inclusion of young people’s descriptions of their experience of depression is required to extend our understanding in this area.

During an extensive literature review, whilst information from a medical perspective was abundant, I was able to find only two studies that recorded the views of young people about mental health. The participants in these studies, however, were not necessarily young people who had experienced mental health difficulties (Moore, 1996; Young, 1997). No studies were located that recorded the experiences of young people who had been diagnosed as clinically depressed. A number of adult accounts were found (Dominian, 1976; Endler, 1982; Hampton, 1975; Nairne & Smith, 1984; Olen, 1993; Papolas & Papolas, 1987; Plath, 1963; Smith, 1996; Styron, 1990), and these perspectives provide the basis for this overview.

I have presented the literature in four areas:

(i) A medical perspective: reports from the medical literature on how young people and adults experience symptoms of depression differently.

(ii) Personal experiences that match diagnostic criteria: accounts from adults who have experienced depression, and whose experiences match information presented in diagnostic schedules.
(iii) Personal experiences that do not match diagnostic criteria: accounts of adult experiences not present in the diagnostic schedules.

(iv) Pilot study experiences: accounts of the experiences of depression recounted by two young people interviewed in a pilot study.

(i) A Medical Perspective

As previously noted, the literature suggests that it is acceptable to use the DSM-IV (1994) for both young people and adults, although there may be differences between these groups in how the symptoms are experienced (Kazdin, 1989; Watkins, 1995). This is thought to result from the developmental differences between young people and adults (Kazdin, 1989).

A review of the medical literature reveals how some of the symptoms are experienced differently:

- **Mood**
  
  Young people’s experiences range from boredom to irritability rather than sadness. Mood is likely to fluctuate widely several times over a single day. Parents of young people may describe noticing erratic behaviour or aggression rather than low mood (Kazdin, 1989; Mufson, Moreau, Weissman & Klerman, 1993).

- **Appetite**
  
  The weight-loss may not be as noticeable in young people, although, as for adults, a loss of taste is frequently described (Kazdin, 1989; Mufson et al., 1993).

- **Sleep**
  
  Changes in the young person’s sleep patterns occur; hypersomnia and less terminal insomnia are possibilities (Kovacs & Gatsonis, 1989; Mufson et al., 1993).
• **Socialisation**

Young people who are depressed may withdraw from their peers, or seek an alternative peer group where they may exhibit “out of character” behaviours such as drug and alcohol use. Alternative patterns of socialisation are believed to create an interruption in the process of individuation from parents as interpersonal relationships are disrupted (Mufson et al., 1993).

• **Motivation and self-esteem**

The net effect of the negative thinking that occurs with depression is a loss of self-esteem and sense of self, a potentially devastating situation for the developing young person (Olen, 1993). If we accept that a sense of self-regard is based on appraisal by others, then it is clear how the negative thinking during depression interrupts this appraisal and leads to decreasing mood and self-acceptance (Beeber, 1996).

• **Decreased energy and concentration**

Both young people and adults experience fatigue and diminished concentration when depressed. The importance of succeeding in the educational system, and the likely impact on the young person’s future when they do not, highlight the significant consequence of impairment in these areas (Kazdin, 1989; Watkins, 1995).

• **Suicidality**

Young people are similar to adults in their depth of despair, sense of hopelessness, propensity for suicide and accompanying anxiety and agitation (Bemporad & Lee, 1988).

(ii) **Personal Experiences that Match Diagnostic Criteria**

A review of the personal accounts of adults reveals that a number of the symptoms of depression present in the DSM-IV (1994) are recognisable in the personal accounts although the language that is used may be different:
• **Depressed mood**
  Depressed mood is identified by such descriptions as ‘endless crying’ (Dominian, 1976, p.16), and ‘feelings of inextricable sadness amounting to melancholy’ (Endler, 1982, p.55).

• **Changes in sleep patterns**
  ‘I hadn’t slept for seven nights. My mother told me I must have slept, it was impossible not to sleep in all that time...’ (Plath, 1963, p.134-135).

• **Changes in appetite**
  ‘Food like everything else within the scope of sensation was utterly without savour’ (Styron, 1990, p.48).

• **Fatigue and loss of energy**
  ‘Physically, mentally and emotionally drained’ (Endler, 1982, p.48).

• **Indecision**
  ‘My indecisiveness was the worst of all. I couldn’t decide what to eat or what to wear’ (Endler, 1982, p.22).

• **Diminished interest**
  ‘I had just about given up hope of ever enjoying anything again’ (Hampton, 1975, p.57).

• **Worthlessness and guilt**
  ‘I honestly felt sub-human, lower than the lowest vermin’ (Endler, 1982, p.45).

• **Thoughts of suicide**
  ‘A belt was a garrote for me, a rope existed to hang oneself with, the top of the door was merely a bracket for the rope’ (Papolas & Papolas, 1987, p.13).

I have highlighted the differences in language in order to demonstrate that having access to people’s descriptions provides a greater understanding of the experience of depression. For example, compare the above descriptions of ‘worthlessness’ and ‘lower than the lowest vermin’.
(iii) Personal Experiences that Do Not Match Diagnostic Criteria: Accounts of Adult Experiences of Depression Not Present in the Diagnostic Schedules
Experiences described in the personal accounts but not discussed in the medical literature provide a broader perspective of the experience of depression. Examples are:

- **Fear**
  ‘It’s fear of not being able to cope, of feeling so remote, of feeling so strange, so withdrawn’ (Nairne & Smith, 1984, p.18).

- **Loss**
  ‘One dreads the loss of all things, all people close and dear’ (Styron, 1990, p.56).

- **Isolation and loneliness**
  ‘I felt an immense aching and solitude’ (Styron, 1990, p.46).

- **Pain**
  ‘Emotional pain is real, it pierces and penetrates the secret hidden places in your body and soul’ (Hampton, 1975, p.74).

The literature also highlights a difficulty for people explaining their experience of depression to others:

> Depression is incomprehensible to those who have not experienced it (Endler, 1982, p.54).

and:

> The experience of depression is not easily put into words
  (Dominian, 1976, p.19).

The difficulty in describing depression may explain the use of analogies such as ‘storms’ (Styron, 1990, p.38); ‘drowning’ (Hampton, 1975, p.74); ‘hell’ (Dominian, 1976, p.20); ‘marshmallow’ (Nairne & Smith, 1984, p.20); and ‘mud’ (Dunnachie-McNatty, 1995, p.37).

(iv) The 1995 Pilot Study Experience
In 1995, I completed an unpublished study that sought to understand the experience of young people diagnosed with medical depression. Two young people who were “recovering” from a diagnosed episode of depression, were
interviewed about their experience of depression. Examples of my findings included the following:

- **Medical signs**
  The two young people described many of the features of depression discussed in the DSM-IV (1994) schedule. The two signs identified as causing the most interference with their day-to-day functioning were sleep disturbance and diminished concentration.

- **Externalising depression**
  They spoke of depression as an external entity separate to themselves but having a significant influence in many areas of their life. I compared this description as similar to one of the techniques of ‘Narrative Therapy’: ‘externalising the problem’ (White & Epston, 1990, p.16). This is discussed in more detail in Chapter Six.

- **A changed person**
  Both participants identified themselves as “changed” when depressed. They related this experience to an altered sense of self.

- **Different or not normal; loneliness**
  A sense of isolation was discussed as the young interviewees described feeling different from their peers when depressed. From their descriptions this sense of difference seemed related to feeling stigmatised by others.

- **Struggling**
  A pervasive theme throughout the research was the sense of enormous struggle the young people experienced when depressed. Every action or thinking process required enormous and unavailable energy.

- **Suicide**
  Both described suicidal thoughts as a part of their experience of depression.

- **Changing back**
  Both identified positive and negative changes following their experiences, and felt that it was unlikely they would return to who they felt they were before experiencing depression.
• **Supports**
  The young people identified the role of their families, significant others and peers as being important in their recovery.

**Shared experiences**
The young people identified the importance of being able to share their experiences with others who had experienced similar difficulties (Dunnachie-McNatty, 1995, p.15-32).

**Comparing The 1995 Study With The Personal Accounts Identified In The Literature**
Medically recognised signs of depression are present in both the 1995 study and the adult’s personal accounts. Other signs common to both included:

• **Feeling different and detached from others**
  ‘People got further and further away until they were like small marionettes dancing up and down’ (Dominian, 1976, p.21); ‘Being with my friends, I didn’t know what to say to them’ (Dunnachie-McNatty, 1995, p.24); ‘A struggle began between it and me for dominance’ (Hampton, 1975, p.57); ‘Is it going to put me in hospital again?’ (Dunnachie-McNatty, 1995, p.18).

• **The stigma**
  ‘I was afraid I would be labeled insane and that would be the end of my career’ (Endler, 1982, p.52); ‘Once a person has been given a diagnostic label denoting a psychiatric disorder, it is difficult to shed it. The label seems to take on a life of its own and supersedes the identity of the individual’ (Bjorklund, 1996 p.1329); ‘Yeah, that’s what they thought, something wrong upstairs’ (Dunnachie-McNatty, 1995, p.22).

To conclude this section, the points that I have made by offering these descriptions are:

(a) that adults and young people experience depression differently;
(b) that whilst personal accounts may describe some of the symptoms present in a diagnostic schedule, a more in-depth understanding of the experience is possible;
that there are a number of experiences of depression that can be identified by listening to personal accounts that are not present in diagnostic schedules.

The descriptions that I have included closely match those of many of the young people with whom I am in almost daily contact. The language that is used provides an insight into the intensity of the experience and the discrimination that is perceived by the young people as being attached to their experience of depression.

1.4.5: Typical Procedures for Helping/Treating Depression During Adolescence

The first step in offering assistance for depression is identifying that a young person is experiencing mood difficulties that are interfering with their experience of life. For parents or caregivers, recognising depression may be complicated by behavioural changes that could be assumed to be a part of adolescent development. The possibility that a young person is experiencing depression is often more likely to be considered by others, for example teachers, school counsellors or friends (Reynolds & Johnston, 1994). Examples of these changes have been described earlier in this chapter and include sleep changes such as hypersomnia (Kovacs & Gatsonis, 1989; Mufson et al., 1993), appetite changes such as changed eating patterns (Kazdin, 1989; Mufson et al., 1993), alcohol and drug use, anti-social acts, loss of interest in previously enjoyed activities and suicidal thoughts (Mufson et al., 1993).

Once depression has been considered as a possibility, contact with a mental health professional may be suggested (Reynolds, 1989). When a young person has been recognised as experiencing depression, a judgment will be made about the level of severity, and decisions made about intervention options. Such factors as the perceived ability of the “helping person” to maintain confidentiality, the young person’s beliefs about mental health difficulties and stigmatisation, and/or the availability of a “youth-friendly” mental health service
will also influence the number and type of interventions that the young person can access (Young, 1997, p.26-27).

A considerable emphasis has been placed on the importance of accessing intervention early for young people who are experiencing depression as this may be one of the determinants in recognising their risk of suicide (Beautrais, 1998; Goldney, 1998; Mental Health Commission, 1987; Ministry of Health, 1996). Assistance can then be offered to promote that young person’s safety from intentional injury (Canterbury Suicide Project, 1994).

A broad range of interventions may be offered, examples being monitoring and support by such primary health professionals as school counsellors or general practitioners and referral to a mental health service (Young, 1997).

The experiences of young people following their referral to a mental health service are offered in significantly more detail in a later section of this report. What follows is a brief synopsis of the range of medical and non-medical interventions a young person may most frequently encounter.

**Medical Interventions**

The range of medical intervention options is offered in two areas:

(i) psychotherapy; and

(ii) medication.

**(i) Psychotherapy**

There are several individual and group therapies that may be offered for the treatment of depression during adolescence. Since the young people in this study make references to therapy they received at a mental health service, the following typical interventions are described.
(a) *Interpersonal psychotherapy for adolescents*

Interpersonal psychotherapy is a structured 12 week therapy that has been adapted for young people experiencing depression (Mufson et al., 1993). This therapy is based on the notion that interpersonal difficulties precipitate and maintain depression (Klerman, Weissman, Rounsaville, & Chevron, 1984). The therapy addresses psychosocial difficulties that are believed to be most apparent when a young person is at their most severe point of depression (Watkins, 1995).

(b) *Cognitive behavioural therapy*

Cognitive behavioural therapy is based on the notion that a key feature of depression is negative thinking (Beck, 1967). Beck suggested that negative thinking tends to have a spiraling effect which results in a lowering of mood. The depression is treated by challenging these negative cognitions. This therapy has been one of the most studied psychotherapeutic interventions for young people experiencing depression (Watkins, 1995). Indications have been that the therapy is effective in treating lowered mood and that it prevents relapse (Fava, Grandi, Zeilezny, Rafanelli and Canastrari, 1996; Wood, Harrington & Moore, 1996).

(c) *Family therapy*

The theory underpinning family therapy as an intervention for young people experiencing depression is that the psychological difficulties can be attributed to a broader disequilibrium in the family system (Carter & McGoldrick, 1988; Quality of Care and Health Outcomes Committee, National Health and Medical Research Council, 1996). There are a variety of family therapies, most aiming to improve relationships and communication within the family by assisting family members to ‘reorganise so they can proceed developmentally’ (Carter & McGoldrick, 1988, p.5).
(d) Psycho-educative and therapeutic supportive groups

These groups provide a secure environment within which young people can learn from others who have experienced similar difficulties with the guidance of a group facilitator (Fine, Forth & Haley, 1991).

(ii) Medication

The use of medication as an intervention for young people experiencing depression has been controversial (Mohr, 1998). It has only been in the last few years that there have been any trials completed that have provided evidence that the use of antidepressant medication for this purpose has been more efficacious than placebo administration (Emstle, Rush, Weinberg, Kowatch, Hughes, Carmody & Rintelmann, 1997).

There are several classes of antidepressant medication. The two that are more commonly prescribed for young people with depression are the selective serotonin re-uptake inhibitors and the tri-cyclic antidepressants. The selective serotonin re-uptake inhibitors are more commonly known as the SSRI.'s. This group includes two of the more favoured antidepressant medications prescribed to young people, fluoxetine (prozac), and paroxetine (aropax). Their favoured status is due to their side effect profile which has improved on some of the older antidepressants such as the tri-cyclic antidepressants; and to their minimal toxicity in overdose (Birmaher, Ryan, Williamson, Brent & Kaufman, 1996; Leonard, March, Rickler & Allen, 1997; Quality of Care and Health Outcomes Committee, National Health and Medical Research Council, 1996). The medication fluoxetine (prozac) has been demonstrated as being effective as an intervention in the treatment of young people with significant depression in a recent trial on a sample of 96 young people. One half of the sample were offered fluoxetine and the remainder a placebo tablet. Fluoxetine was shown to be 'superior' to placebo (Emstle et al., 1997, p.1031).
Non-medical Interventions

Non-medical interventions include the support that is offered by family, peers and significant others, an area that is explored in this thesis. Other interventions include the alternative treatment approaches to medicine such as homeopathy and the use of natural preparations such as St. John's Wort (DeSmet & Nolen, 1996). These are not a focus of this study, but that is not meant as a comment on their importance or possible efficacy.

1.5: Literature Overview: Concluding Comments

The literature in this overview highlights the following points:

- That the development of adolescence is a complex, dynamic process influenced by psychological, biological, cultural and socio-political factors, and is most usefully considered from a contextual perspective.

- The central process during this life-stage is the development of self which occurs during, and as a result of, social interaction. Through social interaction the young person develops social competence in preparation for individuation, a key task of adolescence.

- Any impediment to any part of the process of the transition to adulthood can create a vulnerability to mental health difficulties such as depression. Conversely, the experience of depression during adolescence interferes with the developmental process.

- Factors that promote the potential for vulnerability include the negative labeling of adolescents as deviant, unbalanced, and at-risk.

- The social isolation that results from this labeling increases the vulnerability of these young people to mental health difficulties such as depression.

- When vulnerable young people exhibit features that indicate depression, they are given a medical diagnosis using a diagnostic schedule, the DSM-IV (1994). This schedule is a useful diagnostic tool but it can not explain the experience of depression from the young person's perspective.

- The incidence of clinical depression is increasing each decade and is linked to changes in society.
• The literature discusses several models that attempt to provide an understanding of depression which are based upon the theories of normal development. A model that I have found useful incorporates biological, psychodynamic and psychosocial understandings and acknowledges the importance of context.

• Once depression has been recognised, a young person is offered a range of interventions, some controversial in nature.
CHAPTER TWO: THE METHODOLOGY

2.1: The Methodology: An Introduction

I do not mean to dispute that many forms of depression will one day be found to have common biological signatures... But I do believe that this is only a 'sign' of depression and not a meaning. In order to find a meaning we will have to look at an interplay of lived experience, which is always socially developed, and which will come to include as only one among its many creative sources those very discoveries of neuroscientists (anonymous, in: Karp, 1996, p.20-21).

Why do I believe that a qualitative approach is the most appropriate choice of method for this research? This quotation (Karp, 1996) helps to explain this. I believe that a full understanding of depression is not offered in biological explanations. They ignore the connections that I have witnessed between the responses of a person to their world and their experience of depression. To facilitate an improved understanding of the social contexts that are cited as contributing to, maintaining, and promoting recovery from depression (see Chapter One), a research method that explores human interaction is required.

In the introduction to this research, I described myself as a clinician. My background is in nursing and the area of my interest and predominant employment has been in mental health. For the last seven years I have worked in an area offering a service to young people with mental health difficulties. Throughout my career I have always accepted that my greatest source of knowledge is derived from the contact I have with people experiencing mental health difficulties. The descriptions that I have been given to explain their experience highlight the limitations of using diagnostic schedules such as the
DSM-IV (1994) to describe their difficulties. Two examples of these limitations are:

(i) the inaccessibility to the intensity of the experience; and
(ii) the number of experiences that are not described in diagnostic schedules.

This insight has promoted my belief that research methods that explore people’s experience are an important means of extending knowledge.

My choice of qualitative research has been viewed with some curiosity by many of my colleagues in the mental health branch of medicine. Some are skeptical of the worth of qualitative methods. It is, however, important to acknowledge that qualitative research has for many years been accepted as valid within the discipline of nursing (Schumacher & Gortner, 1992). In fact, there have been many social researchers that have utilised qualitative methodologies to explore psychiatric medicine (Gupta, 1993).

I was introduced to symbolic interactionism during my Masters’ programme (1994-1996) and discovered a methodological fit. This related to my interest in examining how people’s perspectives have developed and how this methodology best suited the area I planned to research: young people experiencing depression. This chapter provides an explanation of the methodology (symbolic interactionism) and rationale for why it is an appropriate fit for this research topic.

2.2: The Research Challenge

In Chapter One I indicated that there are few studies to date that have explored the perspectives of young people experiencing depression. The accounts of the experience of depression I found have been from an adult perspective (Dominian, 1976; Endler, 1982; Hampton, 1975; Nairne & Smith, 1984; Olen, 1993; Papolas & Papolas, 1987; Plath, 1963; Smith, 1996; Styron, 1990).
The challenge that I have undertaken is to utilise a research method that promotes the voice of young people experiencing depression and their caregivers by illuminating their experience of depression and its impact on their lives and presenting this as research which will provide an additional, much needed but seldom reported perspective. Therefore, my overarching question in this research was:

- How do young people interpret and describe their experience of medically recognised depression and what can I as a mental health researcher learn from this?

Examples of possible benefits included that:

(i) by exploring the young people's experience of existing interventions, both medical and non-medical, there would be an opportunity to suggest modifications and alternatives; and:

(ii) by exploring the impact of negative attitudes that are held by some people in society towards young people with mental health difficulties, there would be an opportunity to consider how these attitudes might be modified.

2.3: The Limitations of Current Research: The Need for a Complementary Methodology

2.3.1: Assumptions Underpinning the Research

My research is predicated on the assumption that the study of medicine involves the study of people and that a socio-political perspective will extend the knowledge base by exploring the contexts in which people with mental health problems develop these difficulties. My claim is that medical research has been slow to recognise the experience of depression from an inter-relational perspective. Many researchers working within the confines of the medical model have chosen research methods that do not fully explore the perspective of "the patient". I believe that the reasons for this include:
(i) the continuing beliefs that have been established from the medical model about the patient; and
(ii) the long-held assumptions about the worth of qualitative research.

(i) The Continuing Beliefs That Have Been Established From the Medical Model About 'The Patient'

In a medical model it is the clinician’s perspective that they have knowledge that will "treat patients". They do this by eliciting specific information (symptoms) that will inform a medical diagnosis. Once a person has been given a medical diagnosis they are viewed by health professionals and the general public as sick (Cockerham, 1978; Turner, 1995).

Once recognised as "mentally sick", society pities and fears these people, creating a place for them on the fringes of their community where they may be marginalised and discriminated against (Goffman, 1963; Gupta, 1993). These negative images are reinforced by the media which sensationalises rare events involving people with mental health difficulties including those with depression (Collings and Ellis, 1997). This promotes the belief that the world view of people experiencing mental health difficulties is neither valid nor important (Cockerham, 1978; Fisher, 1990; Goffman, 1963; Gupta, 1993).

There is a follow-on view that these people would not be expected to have information that would be valid to the process of assessing current interventions or developing alternatives. The sole responsibility for "prescribing" interventions would, therefore, remain with the clinicians.

The net result is that the person experiencing mental health difficulties develops a sense of powerlessness which will have a negative impact upon their ability to regain their status in society and to have a voice in the medical world (Fisher, 1990).
(ii) Long-Held Assumptions About the Worth of Qualitative Research

Traditionally many medical researchers have accepted positivist ideologies that have dictated their use of quantitative research methods (Pilgrim & Rogers, 1994). They have been more accepting of testing hypotheses by collecting ‘hard data’ (Bogdan & Bicklen, 1992, p.2), and of exploring objective rather than subjective realities (Cockerham, 1978; Turner, 1995).

I believe that as qualitative methods continue to be used to research areas of mental health medicine, and findings are presented in forums of medical researchers, a growing familiarity, if not acceptance, of qualitative methods as a valuable and complementary research approach is encouraged.

2.3.2: My Position in (and on) the Mental Health System

Being an employee of a system where the majority of employees are clinicians trained in a medical model, I have developed a measure of faith in this system and its practices. I have seen people who, from my perspective, have received treatment for mental health difficulties at a mental health service and over time have returned to their previous functioning. Despite this, my contact with young people who are clients of the mental health system has left me with an impression that more is needed. Although I have seen clients who have recovered very well and have expressed their satisfaction with the treatments that they have received, I have also heard from clients that have felt dissatisfied with their contact and who have not received the help that they expected. There have been caregivers that I have met who have also felt dissatisfied with their offspring’s care. As a result I believe that more can be done to ensure the young person’s experience is a positive one and that their journey to recovery is swift.

In my contact with young people I have collected descriptions of many experiences that have enriched my understanding of the impact of depression at this life-stage. I have shaped my delivery of practice from these understandings. Whilst it is a requirement for health professionals to deliver services that are ‘evidence-based’ (Ministry of Health, 1998, p.32), the development of individual
styles of practice would frequently deviate from classical methods of practice and would therefore not fully meet this standard. For example, my practice is based on my knowledge of the mental health nursing of young people along with an eclectic mix of solution focused therapy (DeShazer, 1993) and interpersonal psychotherapy (Mufson et al., 1993), the experience I have acquired during my twenty-three years working in the area of mental health, and the personal attributes that reflect my self. I believe that if I did not develop my practice from listening to the experiences of people with mental health difficulties and followed very structured models of therapy I would fail to meet the needs of the young people I see. This is an example of the importance of exploring human experience.

2.3.3: Limitations of the Clinician-Client Relationship

The current climate of health funding in New Zealand places ever increasing responsibility on health services to deliver interventions that are measured by output (Ministry of Health, 1998). The emphasis on providing efficient health care to increasing volumes of consumers has encouraged the growth of brief interventions where change is expected to occur within reducing time frames. Sessions are focused and targeted to specific difficulties. Time for exploring areas such as the impact of mental health difficulties on the young people’s relationships, or the effects of discrimination, is scarce.

Furthermore, what clinicians learn from their experience of working with young people must be accepted as occurring within the context of a therapy relationship taking place in a service where a medical model guides practice. The formal nature of the relationship between myself and the clients I have contact with is one of the factors that potentially limits my access to information describing their experience. For example:

(i) the first contact is designed to gather specific information that is used to establish a diagnosis. The information is matched against sets of clinical criteria in the Diagnostic and Statistical Manual of Mental Disorder, (APA, 1994);
(ii) future contacts will be structured according to a management plan that is constructed following the formulation of a diagnosis. The management plan will describe the interventions to be offered. These interventions will reflect what the clinicians accept to be appropriate treatment as well as what they have been trained to practice.

The prescribed nature of the contacts encourages the development of a clinician-to-client relationship where the clinician maintains their ‘institutional authority’ (Fisher, 1990, p.61). The formal nature of the contact and the authority assumed by the clinician are likely to create and maintain a power difference which may inhibit access to information (Fisher, 1990).

I suggest that whilst a considerable amount of my knowledge has been gained through my contact with clients, the type and the quality of the information I am offered may be limited by the nature of the clinician-to-client relationship and the time constraints. A research design that attempts to minimise any factors that may interfere with data collection and uses the descriptions of young people could therefore extend the amount and quality of information that can be gathered through the clinician-to-client relationship.

2.4: The Methodology: Symbolic Interactionism, a Qualitative Research Method

2.4.1: Qualitative Research
Qualitative researchers are concerned with the meanings people attach to interactions and events in their life. Qualitative research methods produce descriptive data including the voices of people recorded in written or spoken form, or accounts of their demonstrated behaviours (Morse, 1994; Miles & Huberman, 1994; Taylor & Bogdan, 1981). Researchers attempt to enter the research field with an open mind as to how the research will develop and what the findings may be. This means that the initial research question may change during the data collection and analysis as the researcher develops concepts and
understandings from patterns that are present in the data. Whilst the researcher may hold assumptions that can be explored, the research is usually conducted in the absence of hypotheses which would pre-ordain the course of the research (Bogdan & Biklen, 1992; Morse, 1994). In other words, qualitative researchers are interested in how people live their lives and how they behave and socialise in their environments (Morse, 1994; Miles & Huberman, 1994). The researcher as much as possible enters the world of the participants, earning their trust and forming informal relationships with them where they are encouraged to share information. This style of data collection has been termed ‘naturalistic’ (Bogdan & Biklen, 1992, p.79). The data collection occurs in settings that are more familiar to the participants than the researcher. Qualitative researchers describe this as ‘field work’ (Miles & Huberman, 1994, p.27; Taylor & Bogdan, 1989, p.25).

The process of data collection and analysis can be represented as a wide-end funnel. Everything connected with the research is considered to be data, from the earliest point possible. Interview transcripts, relevant documents and observation notes are recorded verbatim. All data are coded, categorised, scrutinised for emerging patterns and analysed from socio-political viewpoints. As patterns or themes emerge, the focus of the research becomes sharper as the end of the funnel approaches. Interpretations of meanings and understandings of participants can then be made (Bogdan & Biklen, 1992; Miles & Huberman, 1994).

2.4.2: Symbolic Interactionism

Symbolic Interactionism is a theoretical perspective that sits within the broad collection of qualitative approaches to social research. During the process of consulting the literature on deviance and the effects of labeling (Becker, 1963; Goffman, 1959; Gove, 1975; Laing, 1967; Nunally, 1961; Tannenbaum, 1938), I discovered that some perspectives of negative labeling have contributed to the development of the theory of the Symbolic Interactionists (Cooley, 1902; James, 1907; Mead, 1934).
Symbolic Interactionists believe that people understand their world through their interpretations of their interactions with others (Denzin, 1992). Blumer (1969) explains this as follows:

*They do this by acting on things in terms of the meanings they have for them. These meanings come from interaction, and they are shaped by the self reflections persons bring to their situations (Blumer, 1969, p.25).*

Denzin (1992) claims that the understanding that people take from their interpretations of the responses of others during interaction underpins their developing self. Similarly Cooley (1964) explains that there are dominant groups with whom the individual interacts and the individual’s interpretation of their interaction with these people becomes fundamental to their development of self. These groups include families, peers, and other social networks. They provide an environment where experiences such as conflict and aggression can be played out and interpreted as a basis for further learning and development. As the networks encompass more individuals, the communication that arises from this socialisation promotes the development of a community.

Mead (1934) hypothesised that in the course of communication, common symbols are used which have meanings attached to them that are recognised within the social groupings. Examples of these symbols include events, situations or objects. The symbols provide an impetus for action, so that the communication becomes functional. Within this communication, however, there are many perspectives. Any group of individuals will, therefore, display a diversity of action. These understandings encourage qualitative researchers to study the perspectives of people, paying particular attention to the contexts in which these perspectives have developed. More specifically, Symbolic Interactionists want to address their view that perspectives develop through that person’s interaction with their social environment. The Symbolic Interactionist therefore tries to understand a person’s sense of self in terms of that person’s
interpretation of themselves through their interaction with others (Bogdan & Biklen, 1992).

2.5: The Process

2.5.1: Developing The Research Proposal
An early challenge in undertaking this research was to prepare a proposal that would satisfy several parties: the ethics committees representing the university and the mental health service; the staff at the mental health service who I regarded as the key people that would allow access to the participants, or in qualitative terms, the 'gatekeepers' (Bogdan & Biklen, 1992, p.61); and my supervisors.

The development of the research proposal required several considerations which included attention to who the participants would be, what the most appropriate methods of data collection would be, and how the data would be analysed.

2.5.2: The Research Plan
Drawing on my knowledge of the methodology, information from the literature, and my experiences from professional contact with young people I designed a research plan. The key points of this plan are as follows:

(i) Intention
Broadly, my intention was to design a plan that would enable an exploration of how young people interpreted and described their experience of medically recognised depression. Caregivers' perspectives were also sought in order to explore their interpretations of providing support to a young person experiencing depression.

(ii) Selection of Participants
In order to secure the perspectives of young people experiencing depression, I planned to meet and interview young people who had been diagnosed as
depressed. Whilst it was clearly impossible at the point of preparing a proposal to state how many participants would be enough in order to collect adequate data that would explore the outlined areas, I decided to include a minimum of ten participants. The criteria for selecting participants included the following:

- They would be between 13 and 18 in order to sample the views of younger and older adolescents, and to account for the developmental differences of this age group (Coleman, 1993).
- The participants would include males and females.
- Including both Maori and Pakeha (white Europeans) would provide an opportunity to gain a bi-cultural perspective.
- They would be identified by health professionals at the mental health service as meeting the DSM-IV criteria for 'Major Depressive Disorder' (APA, 1994, p.317). The service uses the DSM-IV (1994) schedule to provide a diagnosis for young people from a medical perspective, this diagnosis being part of a formulation made following an assessment.
- The diagnosis would have been made between three months and one year previously. By excluding young people that had received a diagnosis within a three month period there would be less potential for involving adolescents who had not yet reached a recovery stage of medically recognised depression, and therefore potentially more vulnerable to the interview process (Atkinson et al., 1987, p.503). If the young people were still seriously depressed the likelihood of them experiencing suicidal ideation would be increased. Therefore, requesting them to describe their experiences in an unstructured interview could be stressful and potentially compromising to their safety from self-harm (Atkinson et al., 1987, p.503).
- The young people would consider themselves to be recovering from depression.
- They would continue as clients of the mental health service throughout their participation in the research. A clinician from the service would be available to support them during the data collection. This would promote a safe situation if the interview process (be it focus group or individual interview) became a catalyst for stress, although the counselling skills and professional
knowledge of the interviewer would potentially minimise this. If there was a re-emergence of the medical signs of depression, the young person would have access to a clinician for ongoing support and medical intervention. Whilst I would have a responsibility to inform clinicians of a young person's suicidality, clinical-responsibility as defined by the mental health service would remain with the clinicians.

(iii) Choice of Data Collection

- Participant observation

Participant observation describes a process of data collection where the researcher enters the natural setting of the subjects and systematically observes and records behaviours and interactions, producing 'field notes' (Bogdan & Biklen, 1992, p.92).

A major difficulty in using participant observation in this study had to do with access. There were few opportunities to observe young people with depression communicating with each other. I had explored the possibility of observing a therapy group at the mental health service, although as I had anticipated, this was not possible. I shared the concerns of the clinicians that this would have been intrusive and unlikely to gain approval from the appropriate sources. Similarly, the prospect of observing young people with depression interacting with their families or peers in any setting would have been intrusive. Knowing that many young people with mental health difficulties do not inform others of their situation, I considered that any observation may be counter-productive. It was appropriate, therefore, to interview participants either in a focus group, individually, or both.

- Interviewing, with focus groups or individuals, using either a non, or semi-structured, format

Interviewing provides an opportunity to collect verbatim descriptive data in the participant's words. An analysis of this data provides an opportunity to explore and understand the meaning people give to their experiences, and how their
world views have developed (Bogdan & Biklen, 1992; Miles & Huberman, 1994).

Focus group interviews may be chosen by the researcher as an appropriate source of data collection because in some circumstances individuals’ views and opinions are enriched through group interaction. As Carey (1994) writes:

*With proper guidance from the group leader, group members can describe the rich details of complex experiences, and the reasoning behind their actions, beliefs, perceptions and attitudes. The impact of the group can enhance the quality of data elicited* (Carey, 1994, p.226).

The groups are most effective where the numbers do not exceed four or five, this being considered an optimum number to encourage conversation and a level of comfort amongst participants (Carey, 1994). The use of focus groups with adolescents is supported in the literature where the use of group dynamics is recognised as a powerful medium (Corder, 1994).

Individual interviews, on the other hand, provide an opportunity to describe the perspectives of an individual through an elaborative and extensive interviewing process where open ended questions form the basis of the interview. Sometimes the questions are developed from an earlier group interaction process (Bogdan & Biklen, 1992; Miles & Huberman, 1994).

I planned to obtain written consent from the participants to interview them a number of times over one year. In the first interview they would be a part of a focus group with four to five participants. The focus groups would be recorded using audio-visual equipment. Transcription and analysis would provide me with areas to explore in future individual interviews. Participants would then be interviewed individually approximately monthly for a period of six months. This entire process would be repeated with the remaining participants. The
The purpose of regular meetings was to gain information on the context of each participant.

The interviews were planned to be conducted in an environment of the young person’s choice. Opportunities were home, school, or any place identified by the young person as appropriate. They would be recorded using audio equipment, the tapes being later transcribed and analysed.

(iv) Sample Questions

• Interviews with young people

Sample questions were developed in consultation with my supervisors, using the research questions as a basis for their formation. Different questions were addressed to different people.

• What do you understand by the term “depression”?
• What do you remember about the time you were told that you were depressed?
• What do you remember feeling at this time?
• What do you remember noticing about your thinking, your feelings, your view of your self?
• What would a typical day look like?
• What has happened since the time you were first told: at home, at school, with your friends?
• What advice would you give to another young person who has just been told that they are depressed?

• Interviews with caregivers

Where possible the perspectives of caregivers (predominantly parents) would also be gathered, by the use of interviews. This process could only occur with the young person’s informed consent, and that of their parent or caregiver. The interview questions were similar to those developed for the young people, which provided an opportunity to compare the perspectives of caregivers with those of the young people.
• What is your understanding of the term depression?
• What do you remember about the time the young person in your care was told that she/he was depressed?
• What do you remember thinking and feeling at this time?
• What do you think people around you were thinking?
• How did this time affect your life?
• What has happened since this time, for yourself, the young person in your care, and your family?
• What would you say to another person who had just been told the young person in their care was depressed?
• What is your life like now?

2.5.3: Getting Started: Accessing the Field

In February of 1997 I received information that my completed proposal had been approved by the university. Having already gained approval from both the ethics committees of the university and Southern Regional Health, I commenced the process of gaining access to participants as follows:

• I gained approval from senior managers of the Division of Mental Health and support from the two managers working at the mental health service to proceed;
• I contacted staff at the service and organised a meeting where I described my research and addressed any concerns.

The clinicians' main concern was the maintenance of the young people's safety. They required evidence that strategies had been planned for the times that young people might present with increased suicidality. As the safety of the participants had been a major consideration during the design of the research, the staff were reassured when told that the participants would all be current clients of the service and therefore have continuing access to clinicians. Additionally, the participants would need to agree in advance that if I held concerns for their safety, I would, with their knowledge, be required to inform the relevant staff at the mental health service.
I negotiated with the clinicians that they would approach young people who met the criteria for the study and discuss the proposed research. If they agreed to consider participating in the study, the clinician would pass on their names and telephone numbers and I would contact them to set up a meeting at an agreed upon location, to discuss the research.

2.5.4: The First Meeting

Within a day of meeting with the staff I had been offered the names of three young people to contact, and by the end of three weeks I had met with nine. All of these young people opted to be seen in the first instance at the mental health service saying that this would be the most convenient place. Our first meeting was planned to coincide with an appointment time with a clinician. I then outlined the research and what our respective commitments would be. There were three important ethical issues that I wanted to address with the prospective participants:

(i) the position of the researcher;
(ii) reciprocity; and
(iii) participants’ safety.

(i) The Position of the Researcher

As I was employed as a clinician at the mental health service that the participants attended, I wanted to be sure that they were clear that my role as researcher was not to be confused with that of a clinician. If the participants perceived me to be a clinician, there might be an expectation of a therapeutic gain occurring as a result of our contact. If this occurred, it would be unintentional rather than expected. My other concern here was the possibility that a role confusion could interfere with my access to quality data. There were two potential reasons for this:

- Being perceived by the young people as ‘belonging’ to the service

Being perceived by young people as belonging to the service might have been seen as a threat to their confidentiality. Their concern could be that in my clinician status, I might share information gained during the data collection.
told them that contact with their clinicians would occur only when I held concerns for the participants’ personal safety.

- **The limitations of the client-to-clinician relationship**

The three factors that have been outlined as influencing the nature of the client-to-clinician relationship pertain to the formality of the contact, the “authority” of the clinician, and the limited time that is available for expansive discussion. These factors may influence the extent of a power difference in the relationship between client and clinician which is likely to be greater than in the researcher-to-participant relationship.

If the participants could not separate my clinician and researcher roles, there may be a significant power difference, which may inhibit open discussion and therefore access to data. This could occur owing to the institutional authority that is attached to the role of clinician promoting a one-up relationship (Fisher, 1990, p.61) when compared with the role of qualitative researcher where significant attempts are made to establish as equal relationships as possible (Campbell & Bunting, 1991; Doherty, 1994; Gupta, 1993; Harding, 1995; Lather, 1996; Reinharz, 1992).

The effect of depression on a young person’s self-esteem and confidence was discussed in Chapter One. It is possible that this would further increase their perception of being “one-down” in their relationships. Therefore I believed that the need to clarify my position as a researcher and to attempt to connect with them early in our contact and gain their trust was even more important to the research process.

(ii) **Reciprocity**

The concept of reciprocity (giving something back to the participants in recognition of their valued participation) is a valued tenet of qualitative research (Bogdan and Biklen, 1992).
I wanted to acknowledge the participants’ willingness to be involved in this research. I decided to offer several items in return for their participation. These included assistance with travel to the interviews (if this was required), refreshments during the interviews, a synopsis of research findings at the completion of the research, acknowledgment of the participants in the thesis whilst protecting their anonymity, and the offer of giving them their transcripts. Additionally, I informed the participants that the purpose of this research was to explore areas that would offer the potential for revised and alternative interventions for young people experiencing depression. I also wanted to gain an understanding of experiences such as the stigma reportedly attached to mental health difficulties, and explore ways of addressing these issues. Finally, they were also told that their involvement in the research could benefit others with similar mental health difficulties.

(iii) Participants’ Safety
During the discussion with the prospective participants I acknowledged that the nature of qualitative research could be equated with a journey, one that might be stressful at times. I gave the example of re-visiting the times when they had felt very low, and how for some young people this reflection could be emotionally painful. In order to reassure them I then outlined the strategies that had been established to offer them support:

- Ownership and security of material
The participants had the right to access any of the data collected. They were informed that the tapes would be destroyed once the transcription process was completed. Participants could review the transcripts prior to the completion of the thesis. The transcriptions would be destroyed once the thesis had been completed if the offer of return to the participants was not accepted. All of the data would be stored in a locked filing cabinet until disposal.
- **Anonymity**

Every attempt would be made to protect the identities of the participants. Names would be changed and identifying circumstances would not be described in the thesis.

- **Their right to withdraw at any time**

The participants had the right to withdraw their participation or any data at any point prior to submission of the thesis for examination.

- **Informed consent**

When agreement was reached, written consent was obtained for their participation in the research. If the young person was under 16 years of age, written consent was obtained from a custodial caregiver to comply with the mental health organisation's interpretation of consent.

Where written consent for research participation was obtained, the young people were given a photocopy of the consent form along with an information sheet outlining the research and their involvement (see appendix A).

The reasons for a separate interview with their caregiver(s) were also discussed with them, although consent to contact caregivers was not obtained at this time as it was not required until a later point in the data collection process.

2.5.5: Outcomes of First Contacts

Of the nine young people I initially met with, two decided not to participate on hearing that they would be required to be available for a six month period. One of the two outlined her concerns that she did not want to describe her experience again as she would find this process too distressing. Seven gave their written consent: only five were required for the first round of data collection. I decided that commencing with two extra participants would provide a greater
opportunity to collect expansive and quality data (Bogdan & Biklen, 1992) in the event of participants opting to withdraw their participation during this process.

When requested to participate in both group and individual interviews, five of the seven young people agreed to participate in the focus group, the other two agreeing to the individual interviews only, saying that they were not comfortable with talking about themselves in a group setting.

When caregiver involvement was discussed, three of the young people would not give permission for their parents or caregivers to be involved in the study citing reasons of parental conflict in two instances, and geographical distance in another.

2.5.6: Accessing the total sample
After I had completed the interviews with the first group of seven participants, I approached the staff at the mental health service again to assist me to locate other potential participants. From this process four other young people agreed to meet with me to discuss the research. All four agreed to participate and to have their parents or caregivers involved. Analysis of this data commenced following the first interview.

2.5.7: The Participants (all real names have been replaced to preserve the participants' anonymity).

(i) Lacey
A young Pakeha woman of 18 years of age, Lacey had been in contact with mental health services for approximately three years. She was first told that she was depressed at age 15. Lacey had been admitted to a psychiatric hospital on several occasions since the age of 15 with one of the admissions being of three months duration. When interviewed, she had left school and was employed to care for young people with disabilities. Lacey gave permission for her mother to be contacted for interview.
(ii) Ella
A young Pakeha woman of 17 years, Ella had been in contact with a mental health service for 18 months. She was first told that she was depressed at age 15. In the course of our contact she said that the depression dated back to age 13. Ella was unable to give permission for her caregivers to be interviewed as this would have been geographically difficult. Ella had never been hospitalised. At the time of the interviews she had commenced a tourism course whilst working part-time in a fast food outlet.

(iii) Tess
A young Pakeha woman of 17 years, she had been in contact with a mental health service for 10 months. She dated the depression back to age 15. Tess offered permission for her mother to be contacted for interview. Tess had not had the experience of hospital admission. At the time of interview she had started a forestry conservation programme.

(iv) Suzie
A young Pakeha woman of 19 years, she had been in contact with mental health services for 3 years, and dated the depression back to age 14. Suzie had never been hospitalised. She did not give permission for her parents to be interviewed, and at the time of the interviews she had returned to school as an adult student.

(v) Lachlan
A young Pakeha man of 18 years, Lachlan had been in contact with the mental health service for one year. He dated the depression back to age 14. He did not give permission for his caregivers to be interviewed. Lachlan had never been hospitalised. At the time the interviews he was attending school as a sixth-former.

(vi) Minny
A young Pakeha woman of 17 years, Minny had been in contact with mental health services for one year. She dated back the depression to age 15. Minny had never been hospitalised. She had given permission for her parents to be interviewed and at the time of the interviews she was employed in an industrial position.
(vii) Damien
A young Pakeha man of 18 years of age, Damien had been in contact with a mental health service for one year. He dated back the depression to age 16. Damien had not experienced a hospital admission. He had given permission for his mother to be contacted for interview and at the time of the interviews he was unemployed.

(viii) Kim
A 17 year old young Pakeha woman, Kim had been in contact with mental health services for two years, and dated back the depression to age 14. She had one hospital admission of two months' duration. Kim had given permission for both of her parents to be contacted for interview. At the time of the interviews she was completing her sixth form year.

(ix) Joe
A 17 year old young Pakeha man, Joe had been in contact with mental health services for four years. He dated the depression back to age 12. Joe had given permission for his mother to be contacted for interview. Joe had one five month admission to hospital and at the time of the interviews he was attending school part time.

(x) Kathryn
A 16 year old young Pakeha woman, Kathryn had been in contact with mental health services for one year. She dated the depression back to age seven. She had never been hospitalised. Kathryn had given permission for her mother to be approached for interview, and at the time of the interview process she was attending school part-time.

(xi) Emily
An 18 year old young Pakeha woman, Emily had been in contact with mental health services for two years. She dated the depression back to age 13. Emily had been in hospital on one occasion for two months. She had given permission for her mother to be contacted for interview and at the time of the interviews, she was in receipt of the Sickness Benefit.
Summary of Participants

In summary, 11 young people completed the interviews. All were Pakeha New Zealanders. There were eight women, and three men ranging in age from 16 to 19 years. Five were at school (four part-time), two were on a training course, two were working and two were receiving a welfare payment. All stated that they had been depressed for between two and nine years, the average being three to four years. Four had been admitted to a psychiatric hospital at some time during this period.

2.5.8: The Setting

All of the participants chose the mental health service as the venue for the focus group interviews. They offered two reasons for this: convenience and familiarity. The location of the individual interviews varied between the young people’s homes and the mental health service, or a mixture of both, convenience also being cited as the reason for this. The young people who chose not to be seen at home had several factors in common. They were:

- living at home;
- did not want their parents involved in the research, and
- spoke of difficulties in the relationship with their parents during the process of interviewing (see Chapter Three).

The mental health service is a concrete block building that was developed as a community mental health service following the closure of an adolescent inpatient service. It is located on the periphery of an old, and mostly unused psychiatric hospital. Access is from a side street off one of the arterial roads into the city. The bedrooms of the building have been developed as offices and the waiting area was once a lounge. The interview room was furnished with a desk, four lounge chairs and a coffee table on which there were a number of objects chosen by the clinicians for their visual and tactile interest. The rationale for these objects was described as being a valuable way of allowing the young people to focus on an article that did not detract from the quality of the therapy, but allowed the young person to handle something to decrease the potential
intensity of the client-to-clinician interaction. The small tape recorder was placed on the coffee table and appeared to blend in with the other objects placed there.

The clients' homes varied reflecting the living status of the participants (two of the seven were sharing a flat) and the economic status of their caregivers, which also varied considerably.

As an interviewer I felt comfortable with all venues once I had developed a relationship with the participants, and from my perspective the participants appeared to provide the same quality of information regardless of where they were interviewed.

2.5.9: Data Collection

(i) The Focus Group

During my first contact with the participants I asked them if they would be interested in being part of a focus group. I explained that whilst the focus group would be video taped, the tape could be turned off at any point during the meeting. The participants would have access to the tape and its transcription and could exclude any specific information from the study. Transport could be provided to and from the meeting if required, and refreshments would be offered as part of the meeting. Initially I was enthused by the guarantees of attendance. However, I was disappointed by calls on the day from two of the five young people, one wanting to withdraw from the focus group but prepared to continue with the individual interviews and the other needing to attend another appointment scheduled for the same time. I decided to hold the group with the three participants in attendance to demonstrate my respect for their preparedness to give their time and in the interest in moving on with the data collection process.
The group provided an unparalleled opportunity to identify areas for further exploration in the individual interviews. Despite this, by the end of the group I had made a firm decision not to hold any further groups in this study.

My reluctance had to do with safety concerns. My previous experience of groups for young people with mental health difficulties had been in facilitating group-processes for defined therapeutic purposes. Such groups were generally structured, had clear goals, recruited young people who met specific criteria, and frequently were led by two therapists. These types of groups appear in the literature as therapeutic groups (Corder, 1994). In the focus groups, however, the structure was less formal and the goals less clear. My group skills were successful in engaging the young people so that they moved from being initially quiet and reluctant to talk to all being assertive about having their experiences heard and acknowledged. As the group process continued, however, I recognised that the process tended to encourage a concentration on recent experiences of vulnerability. As the emotional intensity in the group increased I became concerned about how this energy could be managed so that the young people would leave the group safely. This experience clearly highlighted the difference between my clinician and researcher roles.

In my role as clinician, I have developed a clear process of how to explore the degree of safety of those in a group, whilst not escalating their risk of intentional self-harm. In my role as researcher I have developed ways to encourage young people to talk about their experience. I had decided prior to the group that I would avoid encouraging the young people to discuss experiences that might compromise their personal safety. During the process of the focus group I found this strategy very difficult to follow. Suicidal thoughts are clearly intrinsically linked to the experience of depression (APA, 1994, p.322). When young people were asked to describe their experience of depression, suicidal thoughts were a factor that they identified as having in common. Being provided with an opportunity to share common experiences, suicidal thinking became a subject that was raised frequently despite my attempts to steer the group discussion into
other areas. I admitted to having to call upon my therapeutic skills in managing this situation and spent at least half an hour in bringing the group to closure by checking the safety of each participant prior to their departure and reminding them of their support people. The energy and level of skill that this required convinced me to eliminate this method of enquiry from the next round of data collection.

(ii) Individual Interviews
Following the focus group, appointment times were made with the first seven participants. The same questions were used as a basis to commence interviews. By scheduling monthly interviews for six months I was able to observe and explore any movement, forwards or backwards, in the young person’s experience of recovery.

In general, the participants accepted and attended the appointed times at the agreed venues. This surprised me as this degree of punctuality has not been my usual experience when working as a clinician at a mental health service. In retrospect this was possibly a result of the participants’ willingness to be a part of the research compared with their often initial reluctance to attend a mental health service. The information I obtained in the interviews was richer than I had believed possible. In addition I did not have the focus group experience of feeling uncomfortable that I had provided an opportunity that was potentially ‘unsafe’ for the young people. In contrast, several of the young people gave feedback at the end of their participation in the interviews describing the process as, ‘helpful’, ‘enjoyable’, ‘enlightening’ and ‘cool’. This is further explored in Chapter Six.

(iii) Interviews with Caregivers
The interviews with the 8 caregivers occurred at differing points of the interview process with the young people. They were all conducted after I had completed several interviews with the young people and had gained their perspectives in a number of areas. I felt privileged to meet with the caregivers who openly
described their experiences of caring for a young person with depression and the impact on themselves, the young person and their families. Their perspectives were often similar and complementary to those offered by the young people.

(iv) Journal Keeping
Throughout the course of the study I kept a personal journal in which I recorded all of my thoughts regarding the process of the research. The journal included my comments on any interactions which pertained to the research. I also included any thoughts I had regarding ideas for action, notes on references, follow-up ideas from supervision sessions and my perspectives of the research presentations that I delivered. All were noted in the journal and became data that was used as part of the analysis.

2.6: Data Analysis: Issues of Rigour

The collection of data in a qualitative study frequently occurs over an indeterminate time. The process of data analysis is simultaneous with data collection so that each interview highlights areas for further exploration. This process is called the 'constant-comparative method' (Bogdan and Biklen, 1992, p.72), and allows the researcher to follow areas that may not have been identified when the study began. For example, I found that self-mutilation was a topic I could explore until questions about it failed to generate new information. This point is called 'data-saturation' (Bogdan and Biklen, 1992, p.68), allowing the researcher to determine when enough data has been collected.

I conducted seventy interviews in total. Each interview was of approximately one hour’s duration. Each transcription, which I attempted to complete within two or three weeks, averaged twenty-five double-spaced pages in length. In the end I accumulated approximately 1750 pages of data.

The transcriptions and any observer comments that I had added were coded using a coding system developed by Bogdan and Biklen (1992). In this system
data is organised according to ‘situations, settings, activities, perspectives held by participants, ways of thinking about people and objects, process, events, strategies, relationships, social structure and methods category codes’ (Bogdan and Biklen, 1992, p.167-172). Other codes emerged from the data and I soon had in excess of 80 codes. These codes formed the basis of themes for interpretation. For a more complete explanation of the coding system, I have included examples of the coding categories and codes as an appendix (see appendix H).

As the preliminary analysis proceeded, my supervisors reviewed a number of my coded transcriptions and added their feedback. Each participant was offered the opportunity to comment on at least one of their transcripts and five of the eleven young people and two caregivers opted to do this. This process was invaluable as it often opened up areas of enquiry that I had thought had been complete. This continuing analysis allowed me to more accurately judge when the point of saturation had been reached. This occurred towards the end of the period of data collection, although I did not complete the transcription of all the interviews until approximately two months after the last interview.

To account for any further areas of enquiry being identified during the process of preparing the initial draft of the findings, I decided to leave an option open to collect further data. To do this, when I met with the participants for their final arranged meeting, I requested a chance to meet with them again to pursue a new line of enquiry or clarify information already offered. All but one of the participants agreed to this.

Several concurrent activities contributed to my awareness of emerging themes. These included the coding of the transcripts, my addition of observer comments, continued writing and review of my journal, supervision, continued reading in related areas, my attendance at a discussion group for students engaged in qualitative research, and the presentation of my research in a range of forums.
Acknowledging that I entered this study with a set of assumptions based on my work experience, I had to continually check that my prior understandings did not influence how I collected and analysed data by forcing my beliefs onto it. This was achieved, I believe, by including several quality-checks during the research process:

- **Research supervision**
  An important role of my supervisors was reading my coded transcripts and checking that I was not forcing my assumptions on either the collection or analysis of data.

- **Research presentation**
  When I presented my research in forums where the attendees were familiar with qualitative research methodology, I was frequently challenged to describe the process I followed to manage possible researcher bias.

- **Participants' reviewing transcripts**
  Offering the transcripts to young people for reading allowed an opportunity for their comments on the notes I had made during the transcriptions.

### 2.7: Research Dilemmas

In the course of presenting this chapter, I have outlined areas of the research process that I had determined as being potentially problematic. Completing a review of the process, I have included the following five areas where challenges to the process were identified.

#### 2.7.1: Gaining the Confidence of Colleagues Within the Mental Health System

I had anticipated that several colleagues who were essential to the research process in terms of accessing the field and promoting the research would find the concept of my methodology challenging. My understanding was that these people were (are) more familiar with quantitative methodologies. To my surprise, after presenting an outline of my research in several forums, I felt that not only was my proposal accepted, it was welcomed. I assume this was due in
part to the credibility I believe I have established through my work with these people and their perception of me as having a respected place in the organisation. Whilst this was useful in gaining access to the participants, I was concerned that my findings may be threatening to these colleagues since one of the key areas of exploration was the young people’s experience of attending a mental health service.

2.7.2: Participant Profiles
Two dilemmas arose from the selection of research participants. These were:

- **Ethnicity**
There were no Maori in the study despite a request to staff to refer young Maori as potential participants. Approximately ten percent of young people referred to the service identified themselves as Maori and I was at a loss to explain why out of the fourteen young people initially interviewed as potential participants none were Maori. I discussed this with my supervisors and we agreed that whilst a bi-cultural perspective would not be possible, the research was still invaluable in describing a pakeha perspective of depression during adolescence.

- **The current age of participants**
Whilst the ages of the participants at the time of entry into the study placed them in a category of “older” adolescents, it is important to recognise that the majority of participants dated the commencement of depression back to their early teenage years, and were, therefore, in a good position to provide a retrospective account of their experience of depression as young teenagers.

2.7.3: The Vulnerability of Participants
As earlier outlined, in designing this research I had been careful to take an account of the potential vulnerability of the participants throughout the research process. I had been able to satisfy the staff at the mental health service that there were measures in place to ensure the participants’ safety: that all participants were current clients of the service and had access to clinicians if the process became difficult. I had also outlined to the young people that recounting past experiences might be difficult and indicated who they could access if assistance
was required. As mentioned earlier in this chapter, I decided not to hold a second focus group as this appeared to compromise the participants’ safety.

An implication for future research would be to avoid using methods of data collection where there is a potential for vulnerable participants to become emotionally charged, a state that may compromise their personal safety. The importance of this increases when the researcher is unable to adequately recognise the participants’ emotional needs and where the participants are unable to access on-going clinical assistance.

2.7.4: The Inability of Participants to Articulate ‘Recovery’
I had set out to explore young people’s experience of depression during their recovery. I had a perspective of what recovery looks like which may not have matched that of the participants. What I discovered is that the young people were unable to describe recovery as it occurred if indeed it did, but were able to describe recovery retrospectively. From my understanding, the recovery period is generally long, varying from months to years. The participants in this research dated the onset of depression back several years. Defining any change as it occurred during six months then became almost meaningless, although most participants were able to describe some changes by the end of the six month period. The participants were able to articulate feeling changed (which for some I interpreted as their experience of recovery from depression). This was not always described as a positive experience, and this is explored further in the analysis of this research, Chapter Five.

2.7.5: My Position in the Research: The Issue of Emotionality
As earlier discussed, being both a clinician and a researcher became an important consideration in this study. I had embarked upon this research knowing that the participants would be aware that in addition to my researcher status, I was also a clinician at the service. Whilst this dilemma had been extensively addressed during the development of the research design, during the course of the research and my contact with participants there were times that I had felt challenged by
the participants to “be a therapist”, and others where I needed to actively avoid taking on a therapist-role. I felt that some of the participants became confused by the research process and expected me to offer therapy. The literature in this area compares the processes of individual interviews within a qualitative research design and therapy as having several aspects in common (Hart & Crawford-Wright, 1999). This phenomenon is explored more fully in Chapter Six. Additionally, the participants knew about my “other” status. It was, therefore, not surprising that at times I felt that they confused these two roles and I felt unable to prevent this. I had examined this dilemma extensively with research peers (Wilson, Petelo, Hulston & Dunnachie-McNatty, 1999) and concluded that there is a need to explore the issues of entering research where there may be conflicting roles or responsibilities, ensuring that these are clearly delineated and understood before commencing the research.

2.8: Summary of Chapter Two

In this chapter I have introduced the method, a rationale for its use and described issues of rigour. By interviewing young people who have experienced depression and by recording and analysing this information using a symbolic-interactionist approach, I hoped to gain an understanding of the impact of medically recognised depression on the lives of young people. This information would enable me to address the discrimination that I believe young people experiencing depression face, to explore the worth of existing interventions, and to develop alternative practices aimed at minimising the effects of depression on the lives of young people.

What follows is a brief overview of the findings which are discussed in greater detail in Chapters Three, Four and Five.
PART TWO: THE FINDINGS

AN INTRODUCTION TO THE FINDINGS

In Chapter One, I indicated that the development, or arrested development, of a young person is best considered from a contextual perspective. The physical and psychological development of individuals is shaped by their interactions with their environment (Gottlieb, 1991; Lerner, 1982). An environment is made up of a number of variables such as culture, race, gender and socio-economic status. An analysis of the contexts that create environments for adolescent development is necessary to understand how young people manage their transition to adulthood.

A young person’s journey to adulthood will be interrupted by depression. The participants in this study have all been diagnosed with clinical depression. By exploring their perspectives of themselves, their lives, and their experiences of depression, I have described a context in which to understand their experience. This is an area that has not been researched previously.

The methodology underpinning the research plan, the data collection and analysis and the presentation of this analysis all reflect the importance of context and how context has been constructed through the participants’ interaction with their social environment. The meanings they have attached to their interactions is reflected in their view of the world, and their view of their selves (Denzin, 1992).

In this thesis participants’ interviews were analysed and key experiences (which were then defined as key themes) concerning the participants’ relationships with others emerged. These were:

(i) Perceptions of Self Reflected in Self-Concept and Self-Esteem.
(ii) Power, Powerlessness.

(iii) Discrimination/Stigma.

(i) Perceptions of Self Reflected in Self-Concept and Self-Esteem

It has been suggested that negative thinking is linked to the development and maintenance of depression as observed in the young person’s lowered mood and their altered self-concept (Haley, Fine, Marriage, Moretti & Freeman, 1985; Kazlow, Brown & Mee, 1994; Kaslow, Rehm, Pollack & Seigel, 1988; Lewinsohn, Biglan & Zeiss, 1976; Stark, Humphrey, Crook & Lewis, 1990). When a young person is depressed, they construe appraisals of them by others negatively. When a young person has a negative self-concept, it is likely that they will be sensitive to critical feedback in their relationships with others. This experience of a negative sense of self-worth is likely to be heightened by depression.

This may account for why the young people in this study recognised that when they were depressed, their interactions with others often resulted in their feeling more depressed. This is explained in more detail as the analysis continues.

(ii) Power, Powerlessness

If it is accepted that power differentials exist in all relationships (Foucault, 1965) and that young people experiencing depression view themselves negatively, then it follows that their negative thoughts promote a sense of powerlessness. It is therefore likely that where there are perceived power differences such as in the relationship between a young person and a clinician at a mental health service, this sense of powerlessness may be heightened. This would account for some of the young people’s descriptions of powerlessness in many of their interpersonal relationships. This is explored in the next chapters.
(iii) Discrimination/Stigma

If a young person experiencing depression is confronted by stigmatisation or holds stigmatising beliefs about mental health difficulties, it is likely that this will further contribute to their negative view of themselves and the world. This was reported regularly as an experience of the young people and features prominently in proceeding chapters.

From this rudimentary analysis, it is possible to begin to understand the complexity and inter-relatedness of these key experiences and their significance to this research. In order to highlight this significance I have organised the data according to the interpersonal relationships the young people recognised as important. The relationships comprise the next three chapters. They are:

- Relationships with caregivers.
- Relationships with peers.
- Relationships with mental health professionals.

The three findings chapters combine three sets of perspectives: the young people speaking of their own experience, caregivers describing their own experience in addition to their interpretation of their young person’s experience, and my perspective as a researcher who is also employed as a clinician at a mental health service. I have drawn together these three perspectives, completed an interpretive analysis, and clarified findings.
CHAPTER THREE: RELATIONSHIPS WITH CAREGIVERS

3.1: Introduction to Chapter Three

You know, I didn’t know when I got those calls if I would find her alive when I got home... (Anne, in Karp, 1996, p.145).

This quotation (Karp, 1996) highlights the anguish and distress that caregivers experience when the young person in their care is experiencing suicidal thoughts that are part of severe depression (APA, 1994). I have heard similar anguish expressed many times during my contact with caregivers. The anxiety that their son or daughter may have ended their lives whilst the caregivers were away from home or out of contact even for brief periods of time, and that they may be returning home to find that the young person in their care has attempted or completed suicide is unimaginable to me.

During my career I have been privileged to have met many caregivers and I have been in awe at the lengths these people will go to ensure that they are offering every opportunity within their power to support the young person in their care. I have been left with no doubt that these efforts have hastened the recovery process by promoting an environment of protection or resiliency, and I wanted to explore these ideas in this research. Comments from the participants and caregivers on their relationships with each other were mixed, yet the discussion demonstrates the importance of these attachments to the young persons’ recovery from depression.

Relevant Literature

One of the most important concepts when exploring the relationship between a young person with depression and their family is the notion of the family as a system. This thinking is based on the hypothesis believed to have been introduced by Aristotle: that a whole is greater than the sum of its parts. This is
the basis of family-systems theory (Walsh & McGraw, 1996). Change in one part of a family can cause disequilibrium in other areas of family interaction, whilst the family system seeks to maintain an equilibrium where possible (Clarizio, 1994).

The greatest challenges to the equilibrium of the family-system occur at transitional stages of the family life-cycle, an example being the children's arrival at adolescence and the necessary adaptations parents need to make to support the process of individuation (Carter & McGoldrick, 1988). The ability of families to manage this transition is explored in the literature of resiliency to adversity during childhood and adolescence. That literature identified the importance of the role of parents or caregivers in creating protective environments for their children. Examples of factors that promote this protection include a strong attachment of children to their parents from birth, high levels of positive interaction between children and parents and consistent parenting (Baldwin et al., 1982; Bradley et al., 1994; Fergusson & Lynskey, 1996; Greenwood, 1989; Gribble et al., 1993; Herrenkohl et al., 1994; Parker et al., 1979; Seifer et al., 1992; Weintraub & Wamboldt, 1996).

Fewer studies have focused on parental support as a potentially protective or rehabilitative factor during the development or recovery from mental health difficulties such as depression. If we consider the important role caregivers take in providing one of the environments for social competence and therefore interpersonal development to occur (Hauser et al., 1984; Hauser et al., 1987; Leigh, 1986), it is not surprising that positive parenting has been identified as one of the factors that can protect a young person from adversity. It has also been suggested that the family environment can potentially both protect young people from, and contribute to, the development of depression (Hops, 1992; Peterson et al., 1993; Rey, 1995; Ries, Merikangas & Angst, 1995; Rutter, 1989).
Whilst preparing the literature overview I identified three gaps in the current research concerning the role of caregivers in relation to the experience of depression during adolescence. These were:

(i) an understanding of the types of stresses and the context in which they occur that predispose vulnerable young people to depression;

(ii) the examination of family interactional environments as contexts in which depression may occur;

(iii) the exploration of the role of caregivers in a young person’s recovery from depression.

In the present research, these areas were, therefore, explored during my contact with the participants and their caregivers.

**The Data Collection Process**

The participants made many references to caregivers (most frequently parents) during their interviews. Given the importance of relationships with caregivers to the task of individuation (Coleman, 1993; Hill, 1993; Offer & Schonert-Reichl, 1992; Rutter et al., 1976), this is not surprising. This was principally why as a part of the research design, a request was made of young people for caregivers to be interviewed.

Despite my interest in exploring the family environment and acknowledging that this included siblings, the main focus of my investigation was the relationship between the participants and their caregivers. Where relationships with siblings were described by young people or caregivers, this information was included as data for analysis.

Eight of the eleven participants gave consent for caregivers to be approached to participate in the research, and all of these caregivers made themselves available
for interview. Each was interviewed on one occasion only, and separately to the young person in their care. Two of the eight caregivers requested that they not be quoted directly in the text as they felt that this might compromise their relationship with their young person.

**Data Analysis**

The caregivers' perspectives on caring for a young person with depression provided a rich source of data, as did the young people’s descriptions of being cared for. An analysis of the transcriptions of both participants and caregivers provided information in the following areas:

- Family events before the onset of depression.
- Family relationships during the onset of depression and recovery from it.
- The role of family support during recovery from depression.

3.2: Relationships with Caregivers: Findings

3.2.1: Events Creating Context

*Family Events Before the Onset of Depression*

As was discussed in the literature overview, current thinking about the development of depression has moved from the notion that any one factor may be identified in a cause and effect relationship to opting for a more complex interplay of biological and environmental factors (Emery, 1988; Watkins, 1995). It has been suggested that a young person who may be predisposed biologically to depression is more likely to become depressed when confronted with significant stress in their environment than others without this predisposition. This idea sits well with current thinking about resilience and adolescence, identifying why some young people are able to maintain an equilibrium in stressful situations where others do not (Baldwin et al., 1982; Bradley et al., 1994; Fergusson & Lynskey, 1996; Greenwood, 1989; Gribble et al., 1993; Herrenkohl et al., 1994; Patterson, 1982; Parker et al., 1979; Seifer et al., 1992; Werner, 1989).
The participants made many references to family events which occurred before or during their experience of depression. Whilst no causal relationship is suggested, the participants' descriptions of the impact of these events cannot be ignored. I wanted to explore the range of events, and the feelings and emotions attached to these which the young people identified as creating an environment in which their depression developed. The following family events were described by the participants as contributing to their experience of depression.

(i) Marital Separation: The ‘First Listed’ Contributing Factor

Young people spoke directly of the link that they had made between the separation of their parents and depression. Of the seven participants who had experienced their parents separating, all listed this first in their description of significant events contributing to depression. I was curious to know why it was that they had specifically identified the separation as the “main” event, as opposed to other stresses. My first example illustrates this point well: In my contact with Kathryn, when asked what might have contributed to her becoming depressed, she highlighted the distress she experienced at the separation of her parents as being the primary factor that had contributed to her experience of depression:

Kathryn:

My Mum and my Dad separating, that was terrible for me.

I found this description surprising given that during my contact with Kathryn, she continued on to discuss the violence directed towards herself and her mother by her father:

It was physical violence directed towards me and Mum from my Dad.

During our interviews, Kathryn also described the nature of the violence which, from my perspective, amounted to severe assault warranting medical intervention on a number of occasions. This continued throughout much of Kathryn’s earlier childhood. I found it difficult to understand why when asked to identify the stresses experienced that may have contributed to depression, a young person would list marital separation before severe physical violence
allegedly perpetrated by a parent. When I asked Kathryn why she thought this was the most important event, she was unable to elaborate further. This was not the only example of this surprising phenomenon:

**Lachlan:**

> Oh, parents splitting up. Like I don't know why I got so upset cause my father was such a mean dude, I thought things would get better but they didn’t.

When continuing to describe his father’s “meanness” Lachlan referred to the physical violence he was subjected to from his father, which occurred intermittently over many years and frequently required medical intervention.

The literature indicates that violence in many forms may precipitate depression in some young people (Downey & Walker, 1992; Rheinherz, Stewart-Berghauer, Pakis, Frost, Moeykens & Holmes, 1989; Roy, 1985). A physically violent parent abuses their position of authority which results in the child’s loss of control of their environment (Downey, Feldman, Khuri & Friedman, 1994). The child then experiences a sense of powerlessness and altered sense of self, factors that I have argued both contribute to, and are experienced during depression.

Despite acknowledging that the physical violence is likely to have contributed to the marital breakdown, it was not the physical violence that was considered to be the most significant event for Kathryn or Lachlan. A possible explanation is that the violence may have been assimilated into the young people’s reality and they adjusted to it over time by using psychological defenses such as ‘dissociation’. These ideas are situated in the literature exploring childhood trauma (see Briere, 1992, p.37-38). Dissociation, in the context of the young person’s experience of violence, can be thought of as the removal of the experience from their immediate consciousness. Lachlan’s comments elucidate this phenomenon:

**Lachlan:**
I had ways of dealing with it. A lot of the time I just made myself think that it wasn't happening.

Whilst this explanation provides a context of understanding as to why violence would not be considered before marital separation as a primary factor in the development of depression, it fails to explain the significance of marital breakdown. An exploration of the feelings attached to the event of marital separation was more illuminating.

(ii) Feelings Associated to Parental Separation

Several of the participants articulated their strong feelings associated with the separation of their parents. Examples of these feelings included shame, hatred, confusion and fear:

Ella:

Yeh, I didn't want people to know that they had separated. Like they would think of me differently, yeh, so I was so ashamed of that [the separation]. And so I didn't talk about it with anyone. I did struggle with that.

Lacey:

I was really young and knew nothing, but I remember worrying about how to tell anyone, it was such a shameful thing.

Kathryn:

I hated them for it.

Emily:

I was really little but I remember wondering how they could do that to me, I was really confused and terrified.

Lacey’s following description of “shame” at the separation of her parents was greater than the distress she experienced when her father was apprehended for embezzlement and this became public knowledge:
Lacey:

Absolutely, the marriage split was the worst time of my life. I felt so ashamed. I coped with having it printed in the paper that my Dad had stolen his boss’ loot, like lots of people from school had seen it and it was really bad, but it wasn’t as bad as being told that it [the marriage] was over, that was like the end for me.

My interpretation of this is as follows: when we consider the expectations of society regarding marriage and the resultant sense of failure when marriages break down, it becomes less difficult to understand the grief for all involved, including children, when marriages fail. The participants were experiencing feelings of shame and despair related to their beliefs of the stigma that is attached to marital separation. As the literature also suggests that despite the young person’s need for independence, their values and attitudes more often approximate those of their parents (Hill, 1993; Ochiltree, 1990), their confusion and fear may be related to the “double standard” of parents teaching the value of marriage, then choosing separation.

Another explanation may be the guilt that young people are reported as experiencing when their parents’ marriages end (Wallerstein & Kelly, 1980). It has been suggested by Wallerstein and Kelly (1980) that young people believe that their actions, such as misbehaviour, may have directly contributed to the marital breakdown, and therefore they are responsible for the separation. This reinforces their despair. This concept is explored further in the next section.

The importance of the value of marriage to the participants can also be explained from a cultural perspective. The participants are all Pakeha New Zealanders. A part of the pakeha value system (adopted from our European descendants) is that marriage is central to the ideal of family, explaining the significance of marital separation to the participants (Peck & Manocherian, 1988, p.338-367).
(iii) Other Impacts of Marital Separation

Marital separation is a time of change. It is marked by events which include the geographical moving apart of family, the division of property and the renegotiation of such arrangements as finances and (sometimes) friendships, all of which may have a significant impact on children and young people (Peck & Manocherian, 1988, p.338). Any impact on the young person is likely to be related to their sense of loss of control over their environment. Some young people continue to be confronted by the conflict between their parents for a long time after they have physically separated. Contact between parents will occur after separation as they both continue in their parenting role. The conflict may continue, but in other locations. Here are some of the participants’ descriptions in this area:

Kathryn:  

*They moved apart, but things were still bad, in fact Dad got more angry and would make it even more bad for Mum, and I just hated it.*

Lacey:  

*It was like, he was in jail and they were still fighting.*

Ella:  

*They weren't talking to each other much, and like it was so obvious that they hated each other, and I felt like I was in the middle of that, like it was my fault or something.*

The young people noted that despite the geographical separation of their parents, the animosity between them continued. The literature suggests young people may believe that they are the primary cause of their parents’ disputes. They may then feel responsible and guilty for their unhappiness (Wallerstein & Kelly, 1980).

(iv) Another Transition, Moving House

During my work with young people experiencing depression I have often heard them talk about the difficulties that have resulted from numerous geographical moves with their families. Whatever the reason for the move, many adjustments
are required to be made by each family member. As well as moving into a different house in an unfamiliar area, the move may also mean commencing at a new school, establishing relationships with peers, terminating earlier relationships and integrating into new social networks. All of these tasks are likely to be stressful. If in addition, a young person is attempting to deal with the physical separation of their parents, the likelihood of their feeling significantly stressed is understandable. The moves that created distress for some of the participants resulted from the marital separation of their parents. Trina was able to describe a link between the geographical move that accompanied marital separation and depression for Emily:

**Trina, mother of Emily:**

*After the marriage ended she came to live with me and we moved up to Christchurch, but she had a lot of trouble settling. She made new friends, but she missed the old ones. She couldn't settle and spent a lot of time after that going backwards and forwards between her father's and me.*

Ella believed that the sense of powerlessness and distress she experienced at moving between her parents resulted from her feeling that she did not belong with either parent.

**Ella:**

*She [mother] was trying to deal with all her stuff I guess and I just couldn't relate to that, just felt that I didn't belong, but when I went to stay with Dad, it felt like he had moved on and I didn't belong there either.*

Kathryn also describes the powerlessness and loss of control over her environment that she experienced as a result of the many moves after her parents' separation:

**Kathryn:**

*We just kept on moving from house to house, and I know now that we were hiding from Dad, although I didn't understand that then and I hated Mum for it. I got used to not making friends because what was the point?*
From these descriptions an understanding of the significance of needing to move house as a result of marital breakdown is offered. References are made to having to adjust to new social situations, of missing old friends and of feeling disconnected from parents, all clearly stressful events. It is possible that the disconnection from parents would have been exacerbated by the parents’ potential emotional unavailability as they were dealing with their distress resulting from their own transitions.

(iii) Marital Discord
There are several studies that have investigated marital separation and the effects on children. One of the most significant findings has been that children and young people’s adjustment to marital separation is closely linked to the degree of marital discord (Downy & Coyne, 1990; Emery, 1988; Rutter, 1990; Wallerstein & Kelly, 1980).

During the interviews with caregivers there were descriptions indicating that parental discord was a contributing factor to the development of the young person’s depression. An example is offered by Emily’s mother, Trina:

Trina, mother of Emily:

Anyway my first marriage was very difficult, and I often wonder what it must have been like for Emily living in that environment. Like there wasn’t any major physical violence, but lots of arguing and this was all going on under Em’s nose. I would try and walk away, but sometimes that would inflame the situation further. Anyway we did separate and that of course was a very difficult time for Em.

Emily provides her perspective of these events:

Emily:

They used to fight all the time, there was nothing I could do, but I wished for a long time that they hadn’t separated.
Pam, mother of Lacey:

*It was a terrible time for me, we [Pam and ex-husband] argued constantly. God only knows what effect it had on the kids, but Lacey took it the hardest.*

Lacey:

*I couldn't stand the fighting but it was better than the thought of them breaking up.*

Similar perspectives were offered by Damien’s mother, Dawn, and by participants Lachlan and Kathryn when recounting the relationships between their parents. The noted difference between the perspectives of caregivers and the young people was that the young people placed a greater focus on the marital separation than the marital discord. This adds weight to my earlier comments relating to the participants’ beliefs on marriage and the stigma and associated shame they attached to separation. My enquiry continued on to examine the variety of contexts in which young people described their developing depression occurring. Here are some examples.

**(vi) Marital Separation Followed by the Death of a Parent**

For one of the participants, the impact of the accidental death of her father following the separation of her parents was described as follows:

**Ella:**

*For about a week after Dad’s death I was just shell shocked. I couldn’t move, couldn’t do anything. I hated Mum because it seemed like she didn’t care about him, like she had already got over him. But after that I seemed to others to be just my usual self again. It just never really hit home I guess. Even up until just recently I talked about it like I always had this ability to talk about things without showing any emotion, so everybody thought that I had dealt with it. I was fine around lots of people, but when I was on my own I’d be a mess. I couldn’t focus on school. I didn’t know what to do.*
The impact of parental separation followed by the death of her father provides a context for understanding Ella’s distress and subsequent depression.

Studies that have examined the effects of the death of a parent during adolescence have suggested that this would have a significant impact on a young person’s development. The possible effects include depression and anti-social behaviour where the young person has inadequate attachments and limited support following the death (Rutter, 1985), although the literature suggests that a specific incident on its own will not be the cause of depression (Rutter, 1990a). This provides a possible explanation of the distress experienced by Ella.

(vii) Partners
Other participants explained their distress at the introduction of a separated parent’s new partner into their world. Where marital separation has occurred alongside the parents’ development of other relationships, young people face a significant adjustment in redefining their concept of family (Peck & Manocherian, 1988). Several of the participants described their difficulties in dealing with separated parents moving into new relationships and the powerlessness they experienced. Damien relates his relationship with his mother’s new partner as connected to his depression:

**Damien:**

> I spent all my time going between my mother’s and my Dad’s. I stayed with my mother until I got sick of my stepfather, and my old man’s [father’s] until I got sick of his ‘chick’ [partner]. I just kept going back thinking that it would get better, but it didn’t.

I found Damien’s use of language when describing his parents’ new partners interesting. As we discussed this further, I discovered that Damien had entered a conflictual relationship with his stepfather who he described in authoritarian terms, as making attempts to take charge in a parenting role. Father’s new partner was closer to Damien in age than to his father, and Damien’s language
indicated to me that he held limited respect for her in a parenting capacity. This was elucidated further by Damien in the following comment:

**Damien:**

*She's more of a bitch than my sister, and she thinks she's my [expletive] mother.*

Ella relates the difficulties in accepting her mother's new partner:

**Ella:**

*Yeh, and then just dealing with things like Mum getting a new partner then deciding to get married. It was such a short time, and so I always challenged her about that. Like he, [mother's new partner] he wasn't Dad. She would always end up getting emotional, and I didn't mean to hurt her, I just couldn't deal with it.*

**Trina, mother of Emily:**

Trina identifies that moving into a new relationship may have been a factor in Emily becoming depressed:

*By this stage I had met Len too, so even though Emily and Len get along beautifully I wonder what it meant for her realising that I was entering a new relationship. I think all of these things have contributed in some way to her becoming depressed.*

The issues around new partners includes the young people's experience that they are replacing the other parent and that they are attempting to move into a parent role, neither being considered as acceptable. The young person will be concerned that they now have to share their parent with the new partner, and therefore experience exclusion and non-belonging.

**Events Creating Context: Concluding Comments**

These descriptions highlight some of the contextual considerations that contributed to the participants' development of depression. They provide an understanding of the complexity involved in making any definitive statements about the significance of any single event as being a precipitant to a young
person's depression. The literature suggests that these events alone will not necessarily lead to depression, but must be understood alongside other variables, and it is the combinations of these variables that may indicate a person's vulnerability to depression (Hops, 1992; Peterson et al., 1993; Rutter, 1989). The same events may precede other mental health difficulties such as substance use or anti-social behaviour (Rutter, 1985). Findings from a range of studies indicate that there are four areas, three of which pertain to family-styles, that must be considered as contextually significant when considering why a young person may have become depressed:

- biological factors, both genetic and acquired;
- the styles that families have chosen to manage traumatic events such as marital separation; examples being overly structured parenting where the children feel disempowered in decision making processes, or loosely-structured parenting where the children feel an absence of a sense of direction;
- the nature of family structures such as rules; rigid structures reflecting overly authoritative parenting, and the absence of structures reflecting chaotic and disorganised parenting;
- the ways in which families manage emotions; families where there is a high level of expressed emotion being implicated in the development of depression (Hops, 1992; Parker et al., 1979; Peterson et al., 1993; Rutter, 1989).

Whilst the marital separation of parents has been described as the principal precipitant in the development of depression, we must also consider the context in which the marital separation has had an impact on the young person, the family styles of interaction, and the meanings the young people have attached to these interactions. For Damien the marital separation was accompanied by his perceived need to negotiate relationships with his parents' new partners. His language suggests to me that he did not find this transition at all easy, and this was likely to have resulted from the meanings he had attached to new partners based on his construction of marriage. For Emily, additional factors to the
marital separation included her mother’s new partner and the difficulty establishing friendships in a new area. For Ella, the death of her father that followed the marital separation created a context in which her depression developed. What I found interesting was the hierarchy of stresses that the participants offered as significant precipitants of depression. More than a half of the participants had experienced the separation of their parents and all of these young people listed this event first in their description of contributing factors to depression. Possible explanations for this have been explored from a cultural perspective, and the social construction of marriage.

Whatever the “key” events have been from the perspectives of the young people and their caregivers, the key theme throughout all of these descriptions is a strong sense of powerlessness and hopelessness the young people experienced. My understanding of this is that these adolescents felt unable to control their environment, and felt forced into adapting to new circumstances that they neither wanted, nor readily accepted.

The literature suggests that further exploration of multiple family-based stresses and how they influence the development of depression in young people is unlikely to provide any “recipes” that would enable us to identify which young people will become depressed (Rutter, 1990a). Interpretation of the participants’ descriptions of the events that were connected with their depression does, however, contribute further to the notion that the development of depression in young people is extremely complex. It also provides an insight into the uniqueness of young people’s responses to adverse family situations. To develop these ideas further, I explored the understandings of both young people and their caregivers in the following area.

3.2.2: Family Relationships During Both Depression and Recovery
During my work with young people and their families, I have observed how depression affects others in the family, especially caregivers, at many levels. Such information enables others to gain an understanding of the stress that is
created for all family members, in particular caregivers, when supporting and living with a young person with depression.

The interviews provided an opportunity to explore the participants' and caregivers' perspectives of the impact of depression experienced by young people on their family life. An understanding of the family as a system where each family member exerts an influence on family functioning is a necessary concept to consider whilst reading the following section.

Systemic Considerations, the Impact on Family

(i) Caregiver and Sibling Experiences: Juggling, Walking on Eggshells, Frustration, Fear, Missing Out

Hella, mother of Tess:

Hella describes the effects of Tess’s depression on herself and the family:

H: It was hard work. It was a juggling act; like being a peacemaker for the whole family. Like trying to be between her and the rest of the family, even though I know it's not personally directed at me. At times you just want to say 'get the hell out of my life, I've had enough of this', but you don't.

B: What’s that been like for you?

H: There's not a lot of time left for me, but I've got my softball.

B: And is that a sort of a release.

H: Well kind of. I just haven't much energy. Usually I would read myself to sleep, to try and switch off. What I have noticed is the study, I haven't done any study whatsoever. Now it's coming up to about 18 months, longer than I like.

B: And are there other areas that you think you have had to make compromises in?
H: I had to stop relying on Tess for childcare. I couldn’t leave her in charge because of her situation, her impatience; and I had a new job. The other thing is that there was so much anger between Tess and her father. I had to get in between that as well.

In this description Hella identifies caring for Tess as being hard work; frustrating and exhausting (as evidenced by her comments ‘I’ve had enough of this’); requiring her to alter her schedule and to become a mediator between Tess and other family members. Other caregivers expand on these views:

**Mandy, mother of Kim:**

> I think the impact on the rest of the family has been huge. Elie (sister) is very much like Kim. In some ways but not others, you know. I think that it has worried them greatly, and frightened them, and initially they were very, very worried and frightened and fearful for Kim’s well being and what was going to happen to her. They talked about, you know that there was a possibility that she might die. That was devastating. Elie was very much the one who tried to egg Kim on. They have a close bond, and you know, the times she [Elie] would get frustrated and I think it has been a huge thing for them. Sandy the middle daughter, she is quite a different child altogether to the others, and likewise it was very worrying and fearful for her too. There was a certain amount of walking on egg shells. I think the other children do miss out. I have a real fear of that you know you are actually trying to do so much for the one that is unwell that the others are pushed aside to a degree, you don’t do that purposely.

The concern that a young person’s depression had an effect on siblings was a common description offered by caregivers, in particular highlighting their other sons’ and daughters’ sense of powerlessness, frustration and fear. Another area articulated by Mandy but shared by many of the caregivers was the concern that
their other children were “missing out” This was described as being related to
time for individual attention and for family outings. Examples include:

**Joan, mother of Suzie:**

> It [depression] really affected them. They missed out
dreadfully.

**Hella, mother of Tess:**

> They didn’t know how to take her. I think they were scared
of her. Too young to understand.

**Pam, mother of Lacey:**

> Her younger sister really suffered. I didn’t have the time to
help her to understand what was going on.

**Joan, mother of Suzie:**

> Well, I remember everyone feeling really fed up with her
moods. Being told that she was depressed was a real shock,
but we had to think of the other kids too, all the taking her
to doctors and everything, it was really very time consuming
and the others were missing out.

These descriptions highlight the flow-on effects of the young person’s
experience of depression on the family system. Family-systems’ theory suggests
that when the participants were depressed, their behaviours led to a change in
family functioning, having effects on smaller groupings within the family
referred to in the literature as family ‘sub-systems’ (Walsh & McGraw, 1996,
p.44). Examples of these sub-systems include relationships between siblings,
and parents and siblings.

The caregivers’ descriptions provide explanations of the effects of the young
people’s depression on the family system. The perspectives held by family
members have developed from their interaction with their family, one (or more)
of whom has been experiencing depression.
Other systems were also affected by the participants' depression. Here the caregivers describe the effect of caring for their son or daughter with depression on their social interactions:

**Trina, mother of Emily:**

*I felt it was important to respect Emily's wish that people didn't really know what was going on when she was really depressed, so that meant that Len and I stopped having contact with some of our friends. We were also too tired and we couldn't leave Emily. So we did have a lot less contact with some of our friends.*

**Mandy, mother of Kim:**

*I stopped seeing a lot of my friends, I just didn't know what to tell them.*

**Dawn, mother of Damien:**

*I couldn't talk to anyone about it so I stopped going out. I needed to be there for him anyway.*

**Pam, mother of Lacey:**

*I didn't have the time to see anyone, so people stopped calling. It was really hard getting back into it when I finally did have the time and felt better about leaving her on her own. I didn't know how to explain to people what had happened. I still don't.*

**Lacey describing mother Pam:**

Pam's daughter, Lacey was also aware of her mother's changed social situation:

*Mum's friends got out of the way because they couldn't handle it, so she lost friends.*

The longer term effect on the caregivers' relationships with friends was typically described as isolating and distancing. Throughout this research there has been a focus on the stigma attached to mental health difficulties such as depression, and how this has been socially constructed. Several of the descriptions from the caregivers such as Mandy's and Dawn's, included comments that identified the beliefs they have attached to depression and the personal shame they
experienced. Other comments such as Pam's highlighted concerns regarding the stigmatising behaviours of their friends. Once again an insight into extent of the stigma attached to mental health difficulties such as depression is possible.

(ii) Suicidality
Another area that is likely to have a considerable effect on the family system is a young person's suicidality. I believe that one of the most difficult areas for families of depressed young people is having to make sense of the information that their son or daughter has considered suicide. This statement is based on my work with young people and their families. Trying to understand why the young person that they have parented would rather kill themselves than continue to share their lives with their family can be incredibly distressing for caregivers. The prospect for a sibling that their brother or sister has considered suicide can also be very distressing. During my contact with caregivers I have heard a range of comments such as 'where did I go wrong', indicating self blame, and 'how can they be so selfish'.

By exploring caregivers' thoughts regarding the suicidality of their sons or daughters in this study, I hoped to provide an account of the stress placed on parents when young people consider suicide or make suicide attempts.

- Caregivers finding out about their young person's suicidality
The following descriptions are typical of the statements offered by caregivers:

Dawn, mother of Damien:

It was awful. To actually find out that he was suicidal, I didn't know what to do, just horrible. I couldn't accept it for ages.

Mandy, mother of Kim:

Of course I felt guilty, what had I done that she would get to the point of wanting to die. It took a long time for me to accept that it wasn't my fault.
The descriptions included accounts of guilt, self-blame, disbelief, and shock. Another perspective from caregivers was that the young person’s actions were either intentionally harmful, hurtful or selfish. Here are some examples:

**Joan, mother of Suzie:**

*He [psychiatrist] said that she might try and kill herself, it was a real shock, how could she think of doing that to us.*

**Hella, mother of Tess:**

*I think it helped me to believe that she was only trying to get attention and that she really didn’t want to die. I remember thinking at that time just how selfish that was. That if she had died it would have been an accident. I’m still not convinced that she really wanted to be dead, she just didn’t want to be alive at that moment.*

**Pam, mother of Lacey:**

*I remember feeling really angry, that she was just trying to ruin what was a very special day. I now know that she didn’t do it to hurt us, it was where she was at then.*

Given that these comments are offered retrospectively and that some of the caregivers had since reviewed how they felt about the suicide attempts (for example, Mandy and Pam), it is possible that accepting a young person’s suicidality occurs as part of a process, not dissimilar to a grief process (Khubler Ross, 1978). Whilst I have little more to support this idea than my own observations, what I suggest as possible is a continuum (from disbelief to acceptance) with caregivers’ progression occurring in differing timeframes. Movement occurs forwards and backwards and does not always reach either end of the continuum, although over time, a degree of acceptance of the situation is generally reached.

- **Responsibility taken by caregivers to protect young people from intentional self-injury**

During my contact with caregivers, I was overwhelmed at the level of the responsibility that caregivers accept for keeping their young people safe from intentional self-injury. The descriptions of their experiences of caring for young
people where the risk of suicide had been identified offer an insight into this area.

**Trina, mother of Emily:**

_We were just on 24 hour alert. I hardly slept, but we took it in shifts throughout the night. Len [Emily’s stepfather] would try and get some sleep first, and then I would go to bed around four. Every time I heard her get up I would listen. I would hear the toilet door open, and then I would wait until she got back into her own bed. I just never felt good about leaving her. That went on for about four months._

**Hella, mother of Tess:**

_We had her on a 24 hour suicide watch for about a week. We had a friend who came and stayed during the day, and we took it in shifts for the rest of the time. It was exhausting. I worried all the time._

**Pam, mother of Lacey:**

_I had to leave her during the day. I cleaned the house out of everything that she could use to hurt herself. I couldn’t even keep any tablets for my migraines. I would ring her every chance I got, but even so every day I would come home expecting to find her dead. It was awful._

These comments offer an insight into the extraordinary responsibility parents accept in order to promote the safety of their son or daughter, often at considerable cost to themselves and other family members. Once again the impact of depression on the family-system is clear.

_(iii) Altered Perceptions of Family when Depressed_

The ability to offer care to a young person experiencing depression was often hampered by the young person’s reluctance to accept support. I suggest that one of the reasons for this could be connected to the participants’ perceptions of family when experiencing depression:
Negative thoughts, embarrassment

The effect of negative cognitions on the way a young person views their world when they are depressed is well documented (Beck, 1967; Haley et al., 1985). The following descriptions of how some of the participants viewed their families when depressed serves to highlight this.

Kim:
Kim describes feeling embarrassed by her family when depressed, relating this to her perception that other people were "better" than her family.

K: I would think oh, I have such a bad life, thinking that I didn't have any friends and I would feel embarrassed about my parents.

B: Why would you be embarrassed about your parents?

K: Um, because I sort of looked at everyone else in such higher esteem. I would think, oh, they don't seem as good as so and so's parents and they don't do what their parents do, and they don't have that many friends.

Joe and Kathryn shared these sentiments.

Joe:

I felt like the people that were close to me like my father weren't good either, like maybe I had made them bad, but I just felt really embarrassed by them.

Kathryn:

I felt so bad about myself, and my Mum was part of me, so she was bad too.

These comments reflect the negative thinking and resultant low self-esteem of the young people during their experience of depression (Kaslow et al., 1988; Stark et al., 1990). Self-esteem describes how a person evaluates their self-worth (Kaslow et al., 1994). The participants' sense that they are so "bad", and that as they are a part of a family, these people must also be bad. Joe's comments suggest that he was so bad that he contaminated the people he was close to. Some of the caregivers articulated their experience of recognising that
their son or daughter may have negative feelings towards them. Hella and Trina's comments describe this:

**Hella, mother of Tess:**

_I felt sometimes like she hated me, and I didn't understand that except I thought she was blaming me in some way. I couldn't deal with that, I was busy enough blaming myself._

**Trina, mother of Emily:**

_She seemed so angry with us sometimes and I had read enough and heard enough from the staff that that was common, and that it was part of the illness, but it was really hard to keep on believing that at times. It was like she couldn't bear us._

These comments highlight the distress at recognising what they perceived as anger and hatred being directed towards them, thus reinforcing their beliefs that they had been in some way responsible for their young person's depression.

**(iv) Ambivalence**

Ambivalence is an often reported feature of adolescence (Rice, 1990). This was the case during my contact with the participants and was commonly reported in the young people's descriptions of their relationship with parents as the following examples describe:

**Lachlan:**

Lachlan expresses contradictory feelings towards his mother while he was recovering from depression.

L: _Yeh, I think my Mum was really upset because she wanted me to be a good private school boy. I think, well I didn't really realise her dreams._

B: _So something about you believing that the way you were was spoiling an image for her?_

L: _Yeh, I think it wasn't about my education. She wanted to feel that she had been a good mother._

B: _And do you have contact with your Mum?_
L: No, not anymore. She actually tried ringing me but I told her to piss off, after she started trying to tell me like that if I apologised I could come home. In my eyes I had done nothing wrong, so why should I apologise just to; like no way.

B: Do you think that you will have contact with your Mum in the future?

L: For now I've had it, because if I go and see her right now the temptation to crawl back on my hands and knees and say sorry and plead forgiveness would be too great.

Lachlan identifies that he has failed his mother by not meeting her expectations, and whilst he describes feeling angry with her, he also acknowledges that given the slightest of opportunities, he would apologise and return home.

My understanding of ambivalence is that whilst this a common experience for most young people, when a young person is depressed, this experience is magnified. This relates to the indecision that characterises depression in combination with the negative thinking. As an example of this, in a later interview, Lachlan described that he had contacted his mother and that they were meeting on a regular basis. I suggest that as his depression improved he became more decisive, and began to view the world in less negative terms. He was able to recontact his mother; his ambivalence and negative thinking preventing this at an earlier stage of his depression.

(v) An Increased Reliance on Caregivers

Several of the young people realised that during the time that they were depressed, the quality of their relationship with their caregivers changed. They felt this resulted from the increased support that they needed from caregivers when they were depressed. In the following example, Kim describes how depression has caused her to feel more reliant on her parents. She articulates how this change has happened:
Kim:

K: Yeh, I feel like I'm in her shadow at the moment.
B: So when you say at the moment, does that mean that that has been different in the past?
K: Yeh I think that's right because when I was depressed I found it hard to look after myself. She [mother] had to look after me a lot, so I guess I became sort of reliant on her, and that wasn't always how it was. I guess you find it sort of hard to make decisions then. You lose practice.

Similar comments were offered by other participants:

Emily:

I know that she has done so much for me and I love her of course, but it worries me that I can't do anything without her now.

Joe:

I've always been close to Mum, she does so much for me. I used to do more before I was depressed. I wonder if I still can. I've lost my confidence.

I believe that there are several explanations for this. The possibilities include that young people are left with reduced confidence following depression and therefore remain reliant on their caregivers for support, as is described by Joe. The reduced confidence may be result of the negative thinking and the related lowered self-esteem (Kaslow et al., 1994). Alternatively, reliance on caregivers may have developed in a habitual fashion, with parents offering, and young people accepting more support than usual while they are depressed. This is apparent in Kim's comment 'you lose practice'. The decreased social contact with peers that the participants described as a common occurrence when they were depressed may have contributed further to their reliance on parents.

I suggest that the reliance on parents interferes with one of the key tasks of adolescence; individuation (Coleman, 1993; Hill, 1993; Offer & Schonert-
Reichl, 1992; Rutter et al., 1976). This position contributes to their sense of powerlessness, and creates a further obstacle to recovery.

(vi) The Role of Acting

Another area that emerged during the exploration of the young people’s relationships with their parents was their use of pretense, or “acting”:

Throughout the interviews I became aware of how often young people described that they use acting to prevent others from understanding their experience of depression. They would often describe this as a way to have others believe that they were feeling less depressed than they were. From their descriptions, the reasons they chose to act were determined by their audience which included parents, peers, acquaintances and health professionals.

The participants’ following descriptions offer their interpretation of acting when interacting with parents or caregivers:

Lacey:

*I know it was my fault that all these people were affected. I saw that and I felt all of that, so I acted to make Mum feel better because Mum blames herself. You try and hide it by acting.*

Damien:

*It was none of their business [parents], so I wasn’t going to tell them what it was like. So I pretended that I was fine.*

Suzie:

*Sometimes it was easier to act as if everything was fine than to tell them the truth [parents].*

Ella:

*I didn’t have it in me to tell them what it was really like. It was just too much effort and I couldn’t put that on to them anyway.*
My understanding of these comments is that the young people chose to act is as follows:

- Acting served to stop other caregivers asking too many questions such as ‘How are you today?’, or ‘Are you feeling safe?’. If the young people were to answer truthfully they would feel that they were a burden to their family, reflecting their perception of self-worthlessness when depressed; or their activities might be restricted if it was considered that their safety from self-harm was in question.

- Acting was employed to avoid caregivers being disappointed that the young people were not continuing to recover from depression. This again reflects their feelings of self-worthlessness and powerlessness, not wanting to ‘cause trouble’, or ‘get in the way’.

- Acting served to avoid further questions as the young people did not feel they had the energy to engage in conversation. A loss of energy is listed as one of the signs of depression (APA, 1994, p.325), thus not having the energy to engage in further conversation could be understood in the context of the young person’s continuing depression.

Further questioning in this area highlighted the effort and energy of acting for more than a short period of time. Emily’s comments are typical of others:

**Emily:**

> My parents got tired of it so you just pretend after a while that everything’s fine. It’s hard to keep that face on though, it’s exhausting, so after a while you avoid them.

I believe that it is important for caregivers to be aware that depressed young people may act as if they are improved for the following reasons:

- **The issue of safety**
  
  If young people choose not to disclose their suicidality, and caregivers do not suspect it, caregivers will be unable to utilise strategies that maximise safety.

- **The issue of the provision of ongoing support**
  
  If caregivers are unaware of the young person’s depressed mood, they may not be able to offer a level of suitable support.
**The potential for relationship conflict with their caregivers**

When the caregivers are made aware that the young person has been feeling low, and their perception has been that there has been an improvement, there is a possibility that they will not believe that the young person is still depressed. When this occurred for the participants, they described that the conflict between them and their parents created a distancing in their relationship that was a potential barrier to the provision of ongoing support.

(vii) *Differing Understandings of Depression*

Throughout the interviews there are descriptions from both young people and their caregivers that indicate differing perceptions about the nature of depression. For some of the young people interviewed this created conflict. The following comments from Emily highlights this:

**Emily:**

*My Dad didn’t have a good understanding. He tries to be caring but then he says things like, ‘how’s your mental illness going?’ I felt like strangling him, he’s not very good at things like that, or he would say, ‘hello bones’, or ‘fat bum’ or something, not very sensitive. I already felt bad and by saying those things I felt even worse about myself, and he had no idea.*

Emily explains that whilst her father had attempted to understand her situation, he made comments that contributed to her feeling worse about herself, potentially affecting her self-esteem (Allgood-Merton, Lewinsohn and Hops, 1990). He had also revealed some of his ignorance and stigmatising thoughts on mental health difficulties.

**Suzie:**

Suzie describes her mother’s responses that indicate her struggle to cope with Suzie’s depression.

*She [mother] would say stuff like: ‘Like obviously you don’t have depression all the time’. She’s still in the denial stage that I’ve got depression. And then she said that I just had to*
pull myself out of it, like she did because she had post-natal depression. She seems to think she got herself out of it after all the trauma she went through at childbirth but I think she carries it with her.

Comments such as ‘get a grip’ and ‘snap out of it’ were a part of the young people’s experience of interaction with caregivers. Here are some examples:

**Lacey:**

Mum came up to me and told me to get my act together. I think that she was just frustrated with it all, but at the time I couldn’t see that and it made me feel really bad.

**Kathryn:**

I told her [mother] that I had seen someone and they had told me that I was depressed, but she didn’t understand that even though I know that she has been depressed herself. She told me that I just had to get a grip of my life. That hurt at the time.

It is important to acknowledge that comments of this nature were relatively uncommon from caregivers, and more frequently came from acquaintances outside of the young person’s support network. Often when these comments were made by caregivers they were explained as occurring either before the caregiver shared in the understanding of the young person’s experience of depression, or later in the process when both young person and caregiver had been dealing with depression for what had been described as “forever”, and offered in a moment of frustration.

Comments of this nature also occurred when the young person was continuing to act as if they were feeling better, preventing caregivers from understanding the young person’s distress. This is explored further in the next section, parents as supports.
Family Relationships During Depression and Recovery: Concluding Comments

In the process of exploring the relationships between depressed young people and their families, in particular caregivers, the extent of distress that families experience appeared to be significant.

Caregivers offered such perspectives as feeling as though they were juggling family needs with their own, whilst attending to the needs of the depressed young person, creating experiences of fatigue and exhaustion. The feeling that they were “walking on eggshells” when caring for their son or daughter was described as being related to not knowing whether their support was helpful, or whether they were contributing to the depression the young person was experiencing.

Caregivers described a sense of frustration and powerlessness with the process of depression. They described the frustration as being connected to their perception of the young person’s progress, and then discovering that the young person was feeling lower in mood than they had been aware. This was often described as being related to the young person’s attempts to act as if they were feeling better. They also described that their frustration resulted from the exhaustion they were experiencing at the time they felt required to offer support.

The caregivers described the effect on siblings which I have referred to as missing out which resulted from the reduced amount of time caregivers were able to offer their other offspring. Other effects included a reduction in the time they had available to meet their own social needs and the withdrawal from friends that resulted from this. Caregivers also described the impact of supporting a young person who was experiencing suicidal thoughts, and strong feelings such as guilt, self-blame, powerlessness and shock that are associated with recognising that their son or daughter was contemplating suicide. Their process of moving towards self-acceptance is likened to a grief process (Khubler Ross, 1979).
All of these experiences provide an insight into the stress on family relationships that result from living with a depressed young person, and connect with one of the central experiences of this research, powerlessness.

3.2.3: Family Support During Depression and Recovery

A factor in the process of individuation from parents is the changing need for contact (Hendry et al., 1993; McConville, 1995). In my work with young people experiencing depression I have assumed that depression interferes with the task of individuation. I have based this on the observations I have made during my contact with young people along a continuum of recovery. When a young person is depressed, some of the observed effects of depression such as increased suicidality, decreased energy and decreased motivation produce a slowing down of the process of individuation and an increased reliance on emotional support from caregivers. What I have observed is a difficulty for young people and parents in understanding how much emotional support is required as the young person improves, and the conflict that may occur as a result of this. During my interviews I wanted to explore what kinds of support the young people found helpful or unhelpful, to identify for caregivers how to offer support to their depressed son or daughter.

*Caregivers Offering Support, Factors to Consider*

(i) Parallel Experiences

Where caregivers have experienced depression, this may have an impact on their view of their son or daughter’s depression. Of the eight caregivers interviewed, four had experienced and received medical intervention for depression, one had the experience of living with a depressed parent and another a depressed spouse.

The number of caregivers that had experienced depression is consistent with other research findings where family history has been suggested as a factor influencing the incidence of depression. There are a number of studies that have focused on the effects of offspring living with a depressed parent (Hops, 1992; Peterson et al., 1993; Rutter, 1989). A paucity of information exists on how this
experience would influence the way parents who have earlier experienced depression are able to support their depressed son or daughter.

The interviewed caregivers identified that their experience was fundamental to their ability to understand what was happening for their young person. Comments such as those from Trina elucidate this:

**Trina, mother of Emily:**

*I knew exactly how she felt. I don’t believe that anyone can say they know what it’s like if they haven’t experienced it themselves.*

Other caregivers offered similar insights.

**Dawn, mother of Damien:**

*I sort of knew what he [Damien] was going through as I had been there myself.*

**Pam, mother of Lacey:**

*You have to have been there to know what it’s like.*

‘Knowing what it was like’ as a pre-requisite for understanding depression was a comment common to both caregivers and participants, and was also reported by participants when describing their relationships with peers.

What I found interesting was that understanding depression as a result of their own experience did not qualitatively alter how they coped with a son or daughter’s depression when compared with others who had not had this experience. All of the caregivers interviewed described their struggle at “managing” their young person’s depression. This is an area that could be studied further in future research: the differences in supporting a young person experiencing depression when a key variable is the presence (or absence) of the experience of depression for the caregiver.
(ii) Support Described as Helpful

- A non intrusive presence

One of the noticeable statements from the young people pertaining to support from caregivers was that when young people are depressed, they prefer the “non intrusive” presence of caregivers. The following comments explain this preference.

Minny:

> Just having people in the house but not hassling me or asking how I am all the time. That drives me crazy. I feel like yelling at them and telling them to go away. My Mum is worst at it. I know she wants to help but it feels so awful when she asks all the time.

Tess and Emily offered similar statements:

Tess:

> If they were asking me if I was feeling better or if I was all right, that I found really stink. I didn’t have the energy to keep answering them, but just having them around made me feel sort of safe somehow, yeh, like safe from myself. I knew I couldn’t do it [overdose on tablets] again when they were all around, and that felt all right somehow.

Emily:

> I could tell no one [family] knew how to treat me. I knew they were watching me all the time. I felt like they didn’t trust me, but I wanted them to be around. I got tired of them asking me if I was OK all the time, it was really annoying. It would have been better if they were just there but not saying anything. They still ask all the time and it drives me crazy so even though I think they trust me now, often I tell them I’m fine just to get them off my case.

In reporting this finding it is important to acknowledge that whilst the participants found questions unhelpful throughout their experience of depression, it is likely that the reasons for this change as the depression improves. My
explanation for this is as follows: when significantly depressed, a young person does not have the energy to explain how they feel. This was described by Tess and Emily. As they recover, the process of individuation intervenes. To explain this, in the same way that I have repeatedly heard many young people not experiencing mental health difficulties feel frustrated with questions posed by parents such as ‘How was school today?’, their need for privacy, whilst still searching for understanding, drives their frustration at the enquiry of parents.

(iii) The Balance Between Offering Support, and Encouraging Individuation

From the descriptions offered by the participants, I interpreted a need for a continuum of support from caregivers. At one end of this continuum, there is a position of emotional and physical dependence on caregivers when significantly depressed. As recovery occurs, there is a reducing level of support required.

The ability of caregivers to interpret the changing needs of their son or daughter is a complex and difficult task. We have already addressed the young person’s increased reliance on parents during depression and how depression interferes with the process of individuation. The responsibility of caregivers to find a balance that supports the process of individuation whilst recognising the impact of depression is described in the following accounts of caregivers.

Mandy, mother of Kim:

I wanted her to do all of those normal teenage things but I worried about her incessantly. I felt like I didn’t know when things were alright enough to feel secure that it was time for her to start to do those things again. Whenever I would ask her how things were she would just say ‘alright’.

Pam, mother of Lacey:

It became harder and harder for me to work out what was normal teenage behaviour and what was depression. I had to let her do the things that she wanted like be with her friends, but I always worried. I felt I never knew from
asking her how things really were as she would get mad with me.

Trina, mother of Emily:

It is really hard that now that she is getting better I have to learn to let her go and be a teenager again.

(iv) Supporting Young People with Depression: Other Aspects of the Experience

During the interviews with caregivers I became aware of the intensity of the experience of this process. Experiences such as helplessness, self-blame and frustration are examples:

* Helplessness and self-blame

Mandy, mother of Kim:

I spent a long time looking at myself and trying to work out what I may have done for this to happen. I still have times when I believe that all this is my fault somehow and if only I had done something different, been a better parent or something.

Dawn, mother of Damien:

I did everything that I thought was right, I tried to help him but nothing was changing. I felt absolutely helpless.

Trina, mother of Emily:

I just felt so utterly helpless, I just wanted to wrap her in a big blanket.

Hella, mother of Tess:

What was it that I had done, that was what I felt, absolutely helpless.

* Frustration

Many of the caregivers described the sense of frustration that they and their families had experienced. For several, their frustration was presented as an almost palpable powerlessness:
Mandy, mother of Kim:

Initially she [sister] was very quiet and she worried about it [Kim's depression] a lot. I knew that because she would tell me. But now she says things to Kim like 'Oh Kim, you're being so stupid'. I think it's because she is frustrated with how long this has been going on for Kim.

Dawn, mother of Damien:

I felt like I had done all I could and nothing was changing. It was so frustrating.

(v) Families’ Coping Strategies

Having been made aware of the magnitude of such experiences described by the caregivers, I wanted to explore how families maintained an equilibrium when being confronted with this stress.

The caregivers were able to describe the many strategies that they used to support themselves and their families when supporting their young person with depression.

- The needs of others

Several of the caregivers identified how they attempted to recognise and address the needs of other family members. In this example, Mandy highlights the importance of recognising the needs of others in the family, sometimes making difficult decisions to maintain family relationships:

Mandy, mother of Kim:

I had to be normal with a normal routine and so on, and having a chance to talk it through and still trying to do things together as a family. We had planned to go on this trip with another family to do the walk. It was really important for the rest of the family to do that even though it had to be without Kim, although I really struggled to do anything but worry about Kim, even though she was in
hospital and the staff had tried to assure me that she would be OK.

- **Self care: outings and friends**

Mandy continued on to describe how she and spouse S. managed while Kim was depressed.

_I suppose at the beginning we didn’t take time out for ourselves at all, and we’re not terribly social, we’re very much involved in ourselves kind of thing, but I think there was a time when S. said we that we needed to go and have time out for ourselves. Just taking a couple of hours out for ourselves, getting out and having a break. Also I have a very good friend and she’s been marvelous. We would talk about it when we were out running. It was just easy to have someone to sound things off as well as S._

- **Relaxation**

**Trina, mother of Emily:**

Trina describes the activities that she engaged in as a form of relaxation.

_There’s not a lot of time left, but I realised after a while to be able to be there for Em, I had to look after myself. I would read and go for walks, that was a great release for me._

Whilst not suggesting any causal relationship, from the caregivers’ descriptions, a process emerged where the young people’s move towards recovery frequently coincided with two changes. These were the caregivers’ ability to care for themselves, and their ability to address the self-blame that they had experienced.

**(vi) The Importance of Relinquishing Self-blame**

**Dawn, mother of Damien:**

Dawn provides an example of how she moved on from a position of blaming herself for Damien’s depression:

_Well, it's not so much about what I did, it was more how I decided to take it. He [Damien] had started to get better,
and I started to realise that it wasn’t me that was to blame for him becoming depressed. Like it just wasn’t my fault. I had tried to support Damien for years, continuing to beat myself up for not being a good parent. It took someone else to say to me that it wasn’t my fault, and once I had taken that on board dealing with it was so much easier. I did get a chance to talk to some other mothers at [the mental health service] when Damien was going there and they said that they managed by taking time out for themselves and continuing with normal routines, so that really helped too, but mainly it was just accepting that it wasn’t my fault.

This description of Dawn’s exit from self-blame can be viewed as a self-acceptance that is in agreement with an earlier statement that parenting a young person with depression is similar to a grief process. The move to self-acceptance reflects a successful transition through the challenges a caregiver negotiates when the task is to support a son or daughter experiencing depression. For some of the caregivers, this process parallels the move of their son or daughter towards recovery from depression.

**Family Support During Depression and Recovery: Concluding Points**

Descriptions were offered by caregivers and participants, offering their respective impressions of caregivers as supports during a young person’s experience of depression. The caregivers described their feelings of helplessness, and this appeared to be exacerbated by their sense of self-blame; that they had in some way been responsible for the young person’s difficulties.

My earlier belief was that when a caregiver had experienced depression, this may have altered (increased) their resources to offer support, however all caregivers described their struggle at supporting a young person experiencing depression, regardless of their own experience.
Caregivers expressed their difficulty in finding a balance between offering support, and allowing the young people the space to continue with their process of development through their interaction with others outside of the family.

For the participants, the most helpful support was when caregivers were "there" in a non intrusive way, although this may well have contributed to the caregivers' sense that they were not informed enough to know how best to offer support. A significant tension in the supporting process was attending to their, and other family members' needs.

An important dynamic for caregivers was their relinquishing of the self-blame that appeared to occur in tandem with the young person's recovery.

3.3: Summary from Chapter Three

*How Family Events Might Create a Context for the Experience of Depression*

My interpretation of the findings in this area is that it is simplistic to consider depression developing in the absence of context. There are several family factors that influence an environment which may predispose a young person to mental health difficulties. These include: the styles families utilise to manage difficult experiences; the rules by which they choose to operate; the ways in which they experience emotions; and the presence of mental health difficulties in the family history. Important events for the participants in this study were developments within families such as marital separation and associated changes, the death of a parent, and family violence. In several of the families there had been other members with mental health difficulties such as depression. I suggest that an intensive exploration of intra-family interaction within families where a young person is depressed might provide further information on the styles of family interaction that contribute to the development of depression.

*The Impact on Family over Time*

By interviewing participants and caregivers an understanding of the perceived connections between events in their families and the young person's depression
is possible. An understanding of how family relationships may change during the course of a young person’s depression is also possible. Perspectives of the changing nature of relationships within families included the frustration caregivers experienced, alongside the young people’s experience of feeling ambivalent about the support they had received, sometimes feeling that they were not being supported enough, and at other times feeling that they needed space away from family.

**Caregivers as Supports**

- **Caregivers’ experience paralleling a grief process**
  The experience of living with, and supporting, a young person experiencing depression compares to a grief process with a range of emotions that are expressed at points along the continuum of despair to acceptance, movement occurring in no specific order. Associated with this movement was the relinquishing of self-blame which was a part of the caregivers’ healing process and occurred in tandem with the young person’s recovery.

- **Caregivers’ own experience of depression may not change the experience of offering support**
  Some caregivers who had experienced depression themselves felt that this was the key factor in being able to offer support. Despite this, their descriptions which included their feelings of frustration and hopelessness were similar to other caregivers who had not experienced depression. To me, this suggests that this experience does not alter the complexity of supporting a young person through depression.

- **Support versus individuation**
  Some of the challenges caregivers had to manage appeared to be related to the young person’s need for support balanced with the developmental task of individuation. Examples are the need expressed by the young people for privacy, and their reluctance to verbalise their feelings to parents, acting as if they were “fine”.
• **The balancing of needs**

I was impressed by the breadth of the caregivers’ commitment to their depressed son or daughter whilst juggling other demands and attempting to maintain their family in a state of equilibrium. As a researcher I was humbled by their selflessness and honesty.

• **Parallels of experience of young people and caregivers**

Further to my earlier claim that that a caregivers’ experience is likened to a grief process, I suggest that the caregivers’ process parallels the process of depression experienced by the young person. The grief process can be linked to the presence of the key research experiences/themes, powerlessness, stigma and an altered sense of self. To explain this, the caregivers’ sense of powerlessness throughout the process alongside their sense of frustration and distress, appeared to present in parallel to the young person in their care, as did their stigmatising beliefs, and the experience of feeling stigmatised by others. Their sense of a loss of ‘self’ also occurred alongside that of the young people, and appeared to be linked to their sense of isolation, detachment from their social world and their distress related to feelings of self-blame and guilt that they were responsible for the young person’s experience of depression.

**Messages for Parents or Caregivers: Intervention Strategies**

The findings that relate to the participants’ relationships with their caregivers provides information to caregivers on how to support a young person experiencing depression, in addition to an insight into the experience of caregiving during the process of depression. By recognising from a family-systems’ perspective the stress a family is likely to experience when a young person is depressed, supportive interventions can be planned. Examples include:

• **Respite care**

The finding that all family members are affected by a young person’s depression, and the need for parents to have an opportunity to nurture other siblings and care for themselves necessitates that families take time-out. The provision of a range of respite options is therefore recommended. Such
options may be found within the existing family structure or other social networks, or may need to be offered as an adjunct to a mental health service.

- **Social and financial support for caregivers**
  When caregivers are supporting a young person with depression, their lifestyles change. This may involve needing to take time off their employment. The added stress that financial difficulties create must be minimised. There needs to be further provision within the current benefit-payment structure that supports caregivers who need time-out from their employment to support the young person in their care.

- **Family intervention**
  As depression affects all members in a family system, any intervention strategy offered by a mental health service must involve a family-focused intervention.

- **Individual support for caregivers**
  Caregivers in this research acknowledged the considerable effort and responsibility needed to care for a young person with depression. Caregivers' resources were limited by the stigmatising beliefs held by others, and some of their own beliefs on mental health difficulties. The caregivers need individual support where through education and counselling, their feelings of self-blame can be challenged alongside some of the stigmatising beliefs held by, and directed towards them.

- **Meta-factors**
  This research acknowledges that the young people identified breakdowns in family-systems, principally marital separation, as being a significant factor in their experience of the development of their depression. Violence, physical and emotional abuse, and death of a parental figure were also considered to be important. At a society level, the need to support public health initiatives that address the effects of family breakdown and associated factors is considered to be essential to the development of mentally-healthy youth.

**Future studies**
Future studies must be directed in two areas:
• Further investigation of the family environments that potentiate a vulnerability to depression is necessary. This will enable a description of the types of family support that may protect young people from the experience of depression.

• Further exploration of the current belief that family support is fundamental to the recovery of a young person from depression. If this suggestion is favoured by future research, the role of parental support will be given a higher profile in any planned intervention.

Concluding Comments
An exploration of the participants’ and caregivers’ descriptions of relationships within families elucidates the relevance of the three key themes to this research:

• The pervasive sense or powerlessness that is experienced by both the young people, their caregivers, and other family members.

• The effects of stigmatising beliefs that are held by both caregivers and young people, and directed towards both by others in society.

• The perspective of an altered sense of self for both young people and caregivers during the process of depression.
CHAPTER FOUR: RELATIONSHIPS WITH PEERS

4.1: Introduction to Chapter Four

It [helping friends with depression] is a labor of love... It may be hours on the phone and, yeah, it's a pain in the ass...

... Yeah, and it may mean that the paper is not going to be as good as it might. However, you my friend, were worth it (John, age 33 years, in Karp, 1996, p.161).

What happens to friendships when a young person is depressed? Can the friends of young people experiencing depression be as supportive as John (Karp, 1996)? Just how important are relationships between young people anyway?

It was not a surprise to me that during my contact with the participants they made many references to their relationships with their peers. Our contact provided an opportunity to explore how depression affects relationships with peers and the meanings that young people attach to this, and I regarded this as an important area of this research.

My curiosity regarding peer relationships stems from the contact I have had with young people and their unique descriptions of these relationships. Their importance can be observed in the euphoria that is present during their inception, and the strong feelings of rejection and abandonment that prevail if they falter. I am often surprised by descriptions of the intensity of relationships that from my perspective belies their relative brevity. I believe this to be especially true where there is a sexual base to the relationship.

This idea is consistent with available literature (Bradford Brown, Dolcini & Leventhal, 1997). When relationships end, young people's descriptions may indicate that they are in the depths of despair, yet within a time that may be only days, a new relationship has begun and the euphoria has returned. However,
despite this apparent brevity, the literature suggests that stability in peer relationships is a part of the developmental process and tends to increase as adolescence progresses (Berndt, 1982; Bradford Brown et al., 1997; Hartup, 1983).

In my contact with young people experiencing depression, I have been alarmed at the frequency of thoughts of suicide that occur after a relationship breakup, and have witnessed these times as life threatening. I have assumed that the experiences of rejection and failure that are often present when peer relationships end are somehow magnified if these young people are also experiencing depression.

When a young person has been depressed for some time, they will often describe changes in their relationships with peers where they have withdrawn themselves, or their friends have withdrawn from them. I have heard descriptions that have included the experience of being excluded from lunch-time school gatherings, from invitations to parties, and of being an object of curiosity at a school "formal". Assumptions that I have made regarding a young person’s chosen or enforced withdrawal include changes in their ability to relate to others because of the depressive process, or the stigmatisation and ostracizing that has occurred as a result of depression. My time with these young people may involve the exploration of strategies to minimise the opportunity for, or the effects of the perceived discrimination directed towards them from their peers. The insights I have gained from working with young people encouraged my exploration of this area.

**Relevant Literature**

- *Peer relationships during adolescence*

As an extension to the literature overview, a brief review of what is known about the nature and function of relationships with peers is offered. This is followed by the literature exploring the effects of depression on peer relationships as an entrance to the findings.
As I discussed in the Chapter One, a significant part of adolescence is the development of relationships with peers and the meanings young people attach to these relationships (Ausubel et al., 1977; Coleman, 1993; Hartup, 1982; Hendry et al., 1993; Lloyd, 1993). Peer groups define acceptable and unacceptable behaviours for young people. They develop as social networks that allow young people to seek status and identity that is not afforded them in adult networks. Peer relationships provide support and security outside of their family, assist young people to negotiate their independence, and are important in the development of a mature approach to conflict resolution by mutual agreement and respect. Therefore, they act as a training ground for the transition of adolescents to adults (Brown, Eicher & Petrie, 1986; Coleman, 1993; Hendry et al., 1993; Lloyd, 1995; Ochiltree, 1990; Wyn & White, 1997).

Through the process of verbalising beliefs and feelings, adolescents continue to develop an alternate perspective of themselves. This provides an environment where they can continue to discover who they are as their sense of 'self', their identity, develops (Kaplan, 1984; Wyn & White, 1997). Wyn and White (1997) assert that membership in a peer group reflects the young persons' desire to join mainstream society. Where deviant sub-cultures develop as the identity of the peer group, these may reflect the powerlessness that young people experience when attempting to negotiate adult institutions (Wyn & White, 1997).

Attributes of peer groups include that they are often characterised by race, class, sexuality and religious affiliation, and criteria for membership are established accordingly. Ausubel et al. (1977) describe a need for young people to be continually evaluating their group experience within sub-groups. The establishment of sub-groups provides a forum for conflict as others strive for membership. A hierarchy is likely to develop within the group and may be connected to the popularity of group members. Popularity will have been established through the characteristics of group members such as positivity, friendliness, an attractive appearance, confidence and athleticism. Individuals may also have a granted status that occurs when a social standing has been
established through association. An example would be favoured entry to a group where an older sibling has already acquired senior group status (Graham & Rutter, 1985).

There are differences in the quality of friendships both between male and female, and at different ages (Hendry et al., 1993). Young women acquire greater intimacy in their relationships when compared with males in mid-adolescence and girls in pre-adolescence, who would not necessarily view security, emotional support or closeness as important qualities of relationships with friends (Hendry et al., 1993). Popularity for young men and women is measured by numbers of friends rather than the quality of the relationship (Hendry et al., 1993). Relationships with peers in adolescence differ from those in childhood in that they become increasingly exclusive, disclosing, and functional as in the sharing of problems and advice (Ochiltree, 1990).

Peer relationships are based on a completely different set of structural relationships to those with parents in that power is more evenly distributed, they involve reciprocity and are evolutionary through adolescence (Youniss and Smoller, 1985). A study by Leyva and Furth (1986) found that compromises were more likely to be confirmed in peer rather than parental relationships. This was said to be because young people perceived parents as having more power and would therefore win the conflict. The young people felt their views were more likely to be heard and respected by their peers. Despite these different qualities, the group functioning is likely to have been influenced by the same social and economic values as their parents (Coleman, 1993; Heaven, 1994; Hill, 1993; Offer & Schonert-Reichl, 1992).

In a two year study of 1300 adolescents in three Mid-Western USA communities by Brown et al. (1986) it was asserted that the importance of the peer group reduced throughout adolescence. By late adolescence young people favoured close friendships over group affiliation, citing their disinterest in group conformity as being a significant factor in taking this position. Other researchers
have found that young adults can be members of several different friendship
groups at any one time, whilst it was their couple status which was described as
having the most meaning (Coffield, Borrill and Marshall, 1986).

Despite their place in the development of social competence, peer relationships
can contribute to extreme loneliness. This may be because of the importance
young people place on these relationships, the passion related to establishing
themselves as sexual partners and their perceived isolation from family. This
sense of isolation is illuminated in the following comment:

*The negative and distressing aspects of friendship are
rarely explored in the literature (Hendry et al., 1993, p.129).*

- **Adolescence, peer relationships and the experience of depression**

Any disruption to the developmental process may interrupt a young person’s
journey to adulthood. The negative effects of depression on young people’s
relationships with peers can then be viewed as devastating to the transition
process. I found several studies that focused on the effects of depression on peer
relationships. A study by Puig-Antich, et al. (1985) focused on the effects of
depression on academic performance, family, and peer relationships in pre-
pubertal children. They found that even after a sustained period of recovery,
whilst school performance may have improved, these children still experienced
impairment in familial and peer relationships. They also found that the greater
the interference with psychosocial functioning during the acute stage of
depression, the more significant the longer term effects on their relationships
with peers were, continuing on to the adolescent years. Kandel and Davies
(1986) found that a general sense of pervasive dysphoria during adolescence was
likely to be associated with longer term effects on interpersonal functioning,
academic perseverance and anti-social activity. Other studies that concur with
these findings include Garber, Kriss, Koch and Lindholm (1988): that depression
during adolescence interferes with relational functioning and other social
activities, and Altman and Gotlib (1988): that depressed children perceive
themselves as less socially competent.
There were few studies found that focused on the value of peers as supports for young people during depression, although one study by Barrera and Garrison-Jones (1992) found that the significance of support from peers was inversely related to the level of support offered by parents or caregivers. Where strong support was offered by parents or caregivers, peer support was considered as less important to the recovery process. These studies offer some insight into the importance of peer relationships during depression.

**Data Collection**

During the interviews, the two following questions provided an opportunity to explore the participants’ understanding of their relationships with peers:

- What has happened in your life since you were first told (that you were depressed), at home, at school, with your friends?
- What would you say to another person who had just been told that they were depressed?

**Data Analysis**

The data collection and analysis was based on the symbolic-interactionist notion that people make sense of their environment through their interactions with others (Denzin, 1992). Therefore, in this area of the research my focus was on the young participants’ interactions with their peers. The process of coding the data led to a recognition that the three central themes of this research (power/powerlessness, stigma, and an altered sense of self) were multi-present and enabled further development of a knowledge of the perspective of young people experiencing depression.

4.2: Relationships with Peers: The Findings

(i) *The Nature of Adolescent Friendship*

I was interested in the ways that young people described their friendships before they recognised themselves as depressed. The following descriptions are offered:
Emily’s comments about her new friends describe the speed and the intensity of the development of new relationships.

Emily:

I met this girl at ice-skating and she was really great. We went to the movies the next day, and then we met in town. Then R. (partner) and me went camping with her and her boyfriend for the weekend. We got really close.

Kathyrn’s description offers a similar perspective:

Kathryn:

I had to go to a new class and I sat next to a cool girl who invited me to her house after school. I went away with her parents that weekend, we had a cool time, she was really neat. She was my best friend.

Minny describes the difficulty she has in establishing new friendships, and the nature of these relationships when established. Once again the issues of intensity and rapidity of relationships are highlighted.

Minny:

I don’t have many friends, after all the stuff that had gone down for me, but I met this guy at work and we hit it off straight away, like we had so much in common. Like, hell, we’re best mates and we can talk about anything.

The following description from Ella also emphasises the phenomenon of intensity and rapidity in friendships, taking this to another level, where after being newly acquainted, young people would consider living together:

Ella:

Well I started in this new course this week, like it’s taking me a while to settle in, but the others are really connected, like they’ve all been out lots and a couple are going to share flats, it could be a really cool group.

Throughout the interviews there were many examples of this phenomenon. During my contact with young people I often hear descriptions of the intense, but usually brief experiences of rejection, devastation, hopelessness and a sense
of powerlessness when relationships end, and the speedy recovery and rapid entry into new relationships. These observations are consistent with the literature’s suggestions that what separates friendships during childhood to those in adolescence is the development of intimacy in the relationships at adolescence. Relationships are more exclusive, more self disclosing and there is a greater sharing of problems and advice. Young people become totally aware of everything that is going on in each other’s lives. Friends work together to establish their individual identity (Hendry et al., 1993).

Why is this interesting? At one level the idea that the process of peer relationships is intense and rapid suggests their similarity with the very nature of adolescence, a relatively brief period of time during the life-cycle when many important developments occur. If by description the experience of peer relationships during adolescence is intense and rapid, what then is the effect of depression on this process?

It is important to note that an assumption I have made that the participants’ information supports, is that this phenomenon of adolescent relationships is different during and for some time after, a young person’s experience of depression. The following sections explore the participants’ perceptions of friendship.

(ii) Telling Friends About Being Depressed

A key theme throughout this research has been the experience of stigma or discrimination reportedly attached to mental health difficulties. I therefore decided to explore the participants’ experience of telling (or not telling) friends that they were depressed.

A challenge for many of the participants was to decide whether explaining to peers that they had been told that they were experiencing depression was possible or tolerable. For some participants, the decision to tell others was in part based on their own understanding of mental health difficulties, beliefs that I
interpreted as stigmatising, and as having developed during their interactions with others and the media. These beliefs contributed to their distress. The following descriptions elucidate this:

**Lacey:**

> Like I used to think that anyone with mental problems was really loopy, so how could I expect anyone to understand differently just because I was depressed?

**Damien:**

> They would think I was nutty as a fruit cake, like I wouldn’t talk to my mates about things like that, like they would have thought that that meant you were a psycho.

**Kim:**

> I know that I still find it hard to accept that I have depression because of the way that I used to think about what problems like depression meant, so I use that as a bit of an indicator when I’m trying to decide whether or not to tell my friends. Mostly I don’t tell them.

Some of the participants described their concern that telling friends might be too much of a burden of responsibility for their peers. Here are some comments related to this:

**Kim:**

> I used to tell them but I’ve stopped now. I think it might be a burden on them, sort of difficult to handle. I wanted my friends to like me for other reasons. I didn’t want them to feel sorry for me.

**Kathryn:**

> There are a few things like being depressed that I’ve told my closest friends that I have never told anyone in my whole life. It feels better to get it out at first, but then I start to worry that it might be too much for them, like it might turn them away, or it might hurt them or make them hate me. I
sometimes think it would be better if no-one knew anything about me and I could just start again.

Other factors in deciding to tell others related to the experiences of friends or family with depression. Tess provides the following description:

Tess:

I had no problem talking about it because some of my friends had been depressed, although I didn’t tell many people that I had to go to [the psychiatric hospital]!...

...We had an uncle who we used to visit in the live-in part, I found it hard to handle, so what would it be like for my friends?

Tess’s comments identify her concern that whilst some of her peers might be accepting of her depression, they would not be as tolerant about her attendance at a mental health service. This phenomenon is explored further in the section on relationships with health professionals and mental health services (Chapter Five).

The following comments from Suzie describe an ambivalence about telling peers that she was depressed, relating this to a concern that her friends may then treat her differently.

Suzie:

Sometimes I think it’s better when your friends don’t know about stuff like depression because then they like you for who you are, not just because they see you as someone with problems that maybe they can help. Like I don’t want them to feel sorry for me, but maybe they do just by me putting it out there.

Kim shares these thoughts:

Kim:

I stopped telling people because I didn’t want them to feel sorry for me, like I was some kind of a freak. I wanted them to like me for who I was.
If it is accepted that young people experiencing depression have predominantly negative cognitions, it is likely that they will view their interactions with their peers negatively (Henderson, Byrne & Duncan-Jones, 1981). This reflects the negative way the young people view themselves, and their concerns that they will not be liked by others. Their thoughts about how depression will be viewed by others will affect their decision of whether or not to tell their peers. I interpreted their comments on wanting to be liked for "who they are" as a reflection of their discomfort regarding depression, and that at these times they understand depression as being "outside of themselves"; separate to their construction of self.

(iii) Telling Peers and Stigma
From my previous contact with young people experiencing depression, I assumed that some of the participants' concerns about telling their peers of their experience was connected with a fear that they would be rejected. The literature suggests that young people have a strong need to be accepted by their peers (Hendry et al., 1993; Wyn & White, 1997). Peers provide vital intimate feedback at times of rapid change and enable them to communicate as equal partners. Connecting with peers becomes a preoccupation for young people necessitating hours of telephone contact, exhaustive attempts at achieving the right appearance, and a source of major angst when there is a perceived rejection. Reflecting back on the earlier quote (see p.141) from Hendry et al. (1993, p.129) describing the negative aspects of friendship, Hendry offers reasons why some peer relationships falter. Examples are the betrayal of confidence and the "theft" of a partner. Rejection by peers is likely to be a devastating experience for the young person (Ausubel et al., 1977).

Where young people have chosen to tell their peers about their experience of depression, this did not always go as planned. The following descriptions indicate that the participants' disclosures of their experience of depression had been perceived as detrimental:
Kim:

I came with a bit of a past, and people know what's happened to me, and I just find that they're quite catty, and I want to say to them to just grow up. I know that they treat me differently somehow, and are watching out, keeping an eye on me and I don't need that.

Kim feels that she is being scrutinised by her peers which causes her discomfort. Suzie had moved into a new flat and discovered that the young woman who had taken a lead role in organising this residence had not been happy to find out that Suzie was receiving professional help for depression:

Suzie:

I have nothing against her even after all the stuff that's gone down between us. It's just my depression, she can't handle it at all. I just don't get into it now, like I used to leave my tablets in the kitchen sometimes, and it was like a reminder to her that I was a psycho. She really got me thinking about whether or not to tell my friends.

Lacey:

For Lacey her disclosure resulted in some comments that she experienced as frightening, and as being a factor in her confusion of her sense of 'self':

Like I start to think I know who I am, then someone from school or something brings up the loony thing, and well I know it's not really me as a person, it's all the stigma and the vibes coming out kind of thing, but it's really scary, and I get more confused about who I am.

Joe describes how although he had been encouraged to tell his peers that he was depressed, he did not find this supportive. He also offers further information on the phenomenon of depression being separate from a sense of self:

Joe:

I talked with my counsellor about telling my friends and I thought it was probably OK so that they could understand
and be there. No one really did though, maybe it was too much for them, they just seemed to not be able to handle it.

For all of the participants, the process of sharing information about their depression with friends was described as a trial and error situation with no single answer to the question of whether to tell or not. Where the participants offered similar information, it was that “telling” should be a very carefully thought out process to a select number of people.

(iv) Perceptions of Friendship When Depressed

- **Negative thinking and self-worthlessness contributing to a changed perception of self**

The following description from Suzie explains the barriers she has located within herself that inhibit her entrance into new relationships:

**Suzie:**

I could say that I have no friends but there are people out there who might say ‘Hey, I am’; like I just don’t see it. People might say to me ‘Oh, you’ve got nice hair’, but I’m not going to believe them, I just dismiss it. It’s got to come from myself. When someone is saying ‘Oh you have nice eyes’, when I am saying that I hate myself and the world is awful, I feel miles away from them. And then I find myself thinking that they don’t really like me, I’m thinking that I’m of interest to absolutely no one, and no one cares whether I’m there or not. Like I will be taking all the vibes in a negative way. Like if someone’s body is twisted the other way I will be thinking oh God, I’m so boring, they’re not interested in me. When I’m getting better I can see that all these people that I feel have it all going for them are really not as on top of it all as I had believed. I used to define who I was by what others’ thought of me, and I judged that by what they said and how they looked at me. That was when I was depressed.
Suzie’s description of her ‘negative vibes’ and low opinion of herself compared to others, is typical of many of the participants’ descriptions of relationships with peers when depressed. I have interpreted this as an altered sense of self which is a consequence of the negative thinking that occurs when a young person is depressed (Beeber, 1996; Olen, 1993). For Suzie, an attempt to describe her self was dependent upon her choice of peers. Her interpretations of the responses from her peers during their interaction would determine how she perceived herself. Kaplan (1984) describes how young people may choose peers that offer them the identity that they have defined for themselves. Peers are chosen because they meet the young person’s needs to identify with a part of their self, in as much as their peers help to define their self. A symbolic-interactionist’s interpretation of Suzie’s experience is that her absence of a sense of self means that she takes on the persona that she perceives others to have given her. As these perceptions are always negative when she is depressed, her view of her self is reinforced as a negative view. Earlier descriptions of ‘the looking glass self’ (Cooley, 1956) complement this understanding. The self of the person is reinforced by the person viewing themselves in a negative way. The negative thinking and the associated altered sense of self that occurs when a young person is depressed creates a sense of hopelessness and powerlessness that pervades all interactions. Other examples of the impact of negative thinking on peer relationships are offered by Lacey, Lachlan, Kathryn, Emily and Emma:

Lacey:

_I hated myself so how could I expect any of them to like me_?

Lachlan:

_I was pretty much an arrogant bastard when I was depressed so I lost a lot of friends. Hell, I hated myself so how could I expect anyone else to like me._

Kathryn:

_I felt like I had nothing to offer them, they were so cool and I was a nif [no-friends]._
Emily:

*If they invited me out I couldn’t go. The truth was I felt just too hopeless to do anything, it was out of my control.*

Ella:

*I had one friend say to me, ‘what’s wrong with you, why aren’t you talking?’, and at that stage I didn’t know what was wrong, but I realised that I was some kind of burden to them, but I felt like I just couldn’t do anything about it.*

All of these comments demonstrate the hopelessness and powerlessness the young people experienced. In Ella’s situation, she felt so bad about herself that she felt that she was a burden to her friends, but unable to do anything about this. This sense of self-worthlessness was evident throughout the descriptions of depression in the research. The following descriptions explore this further:

*Belief in Self: Self Worthlessness*

Suzie:

*I had no confidence before I was depressed, my self-esteem was really gone and I hated myself then, so when I was depressed all that was even worse. I reacted to everything people said about me. I believed that they were talking about me, even my best friends, thinking I was nothing. A piece of excrement on the pavement.*

Damien:

*I just thought that I’d had an apprenticeship and two jobs and it hadn’t worked out, I just thought, loser type of thing. I never did School-Cert. I just thought I was a yam.*

Minny:

*Nobody liked me and I didn’t like myself, so what was the point of going on. I had no future and no one could help me. I felt really stupid.*

This comment from Lacey provides an insight into the spiraling nature of negative thoughts, disconnectedness and withdrawal, and the consequences that occur as a result:
Lacey:

It's like you have to end relationships because you aren't good enough for those people anymore. You're in a good relationship and you stuff it up. It makes it worse.

These comments describe how the young people felt when they were depressed. I found it interesting that for some of the participants, a sense of self became more confusing during recovery. This confusion related to a difficulty adapting to an improved well-being, and the impact of this change on their sense of self as follows.

- **Recovery and confusion: A sense of self**

The following comment from Lacey highlights the sense of loss of personal identity or an altered sense of self not only when depressed, but also during her recovery.

Lacey:

I did get better for a while but it totally scared the shit out of me because I was such a different person to what I thought I was and I went back so I wouldn't have to feel strange anymore. I was on medication and I was getting better quite quickly. I'd tried lots of medications that didn't work, and then all of a sudden, I think it was lithium, I just felt good again, and I felt confident and I had all of these things I had never had before and I felt so uncomfortable. My friends knew me better than I knew myself, and when you are stuck with a personality you don't really know, it's quite scary. I got quite upset about it and kept telling everyone it wasn't me and I didn't want to be like this.

For Lacey, a recovery which she perceives resulted from medication, resulted in her becoming increasingly improved in her sense of well-being to the extent that she had become more confused about her perception of self. Despite experiencing changes that would be argued from a medical perspective as indicators of successful treatment, Suzie found them difficult. This is explored in greater detail in Chapter Five. This final description from Suzie completes
this section on the participants’ negative thoughts and the impact on a sense of self when depressed:

Suzie:

*It's just when all the negative thoughts start coming in and take over really. I've been really molded by my surroundings. My main struggle at the moment is just finding out who I am.*

- **Disconnectedness from friends and subsequent withdrawal**

Linked to the participants’ experiences of an altered sense of self, some of the participants described a disconnectedness with friends that interfered with their ability to communicate. For some participants this related more to a disconnection with self rather than directly with friends. The result of disconnection might be a choice to withdraw from friends so that they would not have to feel responsible for these relationships. This is described by Ella:

Ella:

*I couldn't ask my friends for help when I was depressed, like that's when I knew something was wrong because I was back with all my friends at the school that I liked and something was still not right. I felt like I had lead inside of me. I would be with my friends but would be just staring into space not saying a word, it was like I was another person, like completely detached from it. I could be talking about my Dad and his death and it was like it never happened to me. It was like watching a TV show and I could not take part. I used to think that I didn't care about my friends because stopping caring means you don't have to do anything. Like I didn't have to take any responsibility for them then.*

I suggest that Ella’s comments of feeling as if she was watching a television show that she could not participate in are linked to experiences of a disconnection or a dissociation from the external environment. As explored in
Chapter Three, this experience is reported in the literature relating to the effects of trauma (Briere, 1992).

Several of the participants described similar experiences which appeared to provide a protection against having to examine what was happening on an interpersonal level at that time, in the same way that dissociation is thought to operate (Briere, 1992). From a symbolic-interactionist perspective, the trauma is linked to the participants’ beliefs about how they will be responded to by others, based on their beliefs about themselves that have developed during their interaction with others. Here are some examples:

Emily:

*It was a like a dream that I was watching but was also a part of, like I could deal with the people if I wasn’t actually thinking about what was happening, not being me.*

Tess:

*I used to spend the day with my friend Barb, and like, looking back, it was like I was there but I wasn’t, like I was looking at myself from somewhere else, and Barb and me weren’t talking.*

Kathryn:

*I used to go to school and be with my mates at breaks, but it was like that wasn’t me, like I was watching myself be like I was someone else, it was kind of easier that way I guess.*

These comments also indicate a sense of disconnection from ‘self’ that I have explored throughout this chapter, this resulting from negative thinking and feelings of self-worthlessness; experiences commonly described during depression.

For some of the participants, a sense of disconnection from their peers served to reinforce their beliefs that their friends no longer cared for them, and therefore they would not have to be concerned for these people. Ella articulated this as ‘not having to take responsibility for them’. For some of the participants, a
disconnection with their peers coincided with a move to other groups of peers where the demands for interpersonal interaction were reduced. As an example, Lacey describes that whilst feeling disconnected to her friends at school, the people she felt most at ease with were friends of her partner who were possibly disinterested in interpersonal communication or unable to connect owing to their substance-altered states:

Lacey:

_\text{I went over to my boyfriend's house and would just sit there day after day, unable to do much, like even unable to move.}
_\text{His mates didn't mind that I didn't speak as they used to be stoned all the time anyway so they didn't speak either. I probably would have felt better if I was stoned too.}_

For Lacey, her description implied that her sense of disconnection was related to a physical inability to move freely. Kathryn described this as being ‘frozen’, and Lachlan as being ‘stuck like glue’. From a medical-perspective, these descriptions would be equated with the DSM-IV (1994) medical description of ‘motor retardation’ (APA, 1994, p.327) whereas from a person-perspective, as seen in the personal accounts of people experiencing depression (Dominian, 1976; Nairne & Smith, 1984) they are much more illuminating than what can be learned from a diagnostic schedule. What is important to note here are the clear differences between descriptions in diagnostic schedules, and the language used to describe personal experiences.

From the participants’ comments, it seems clear that the DSM-IV (1994) is unable to describe depression in a manner that allows a full understanding of the experience. A focus of this research has been to highlight the differences in how depression is described in diagnostic schedules, and how it is described by those young people experiencing it. In their descriptions of their interactions with peers, the participants have articulated these differences well, demonstrating the importance of providing a complementary perspective.
Another reason for withdrawal from relationships with peers

Other participants described their isolation as being connected with their changed needs for personal space. The following description from Suzie offers her thoughts on the changing needs for personal space that occur during the process of depression and recovery:

Suzie:

I guess I'm getting better at having people around me. Like when I was depressed it was like don't get too close, I've got to keep this personal space, like you need more of it when you are feeling depressed or something, but now I like being around people, like I like to be close.

Other participants' comments offered a similar insight:

Ella:

Maybe it was a part of feeling so out of touch with everyone, but I couldn't cope with them being too close, yet at the same time I felt so lonely.

Lachlan:

I felt like: 'get out of my face', I don't have that now.

I understood the participants' need for personal space when experiencing depression as being connected with their inability to feel comfortable with interpersonal interactions, and their propensity to avoid these situations, despite their concurrent sense of loneliness and isolation.

Disconnection from peers often resulted in physical and social withdrawal. The effects of withdrawal included the distancing or severing of relationships, and the associated difficulties during recovery of re-establishing these relationships. This description from Emily highlights these difficulties:

Emily:

I really didn't want to be around anyone, like I felt as though they were all staring at me. I would curl up in bed rather than talk to anyone, I didn't like to communicate with anyone, even my friends. My worst nightmare would have
been being asked to be in a team game or something, just trying to communicate was awful. I was always on the outside looking in, just couldn’t do anything. I got farther away from my friends to a point where now, getting back with them ever again seems impossible.

From her description, Emily believes that despite being in a recovering position from depression, she feels that it is unlikely she could rebuild relationships with her peers. Ella offers her perspective of why rebuilding peer relationships might be difficult:

Ella:

You would keep on pushing people away from you so that when the time came that you needed their help they would be confused or not there as you had pushed them away so many times already, and they are so far away then you don’t know what you can do to get them back.

(v) The Spiral Theory

There are several “cause and effect” events that are observable in the interactions of a young person relating to peers when depressed. The negative thinking results in physical and social withdrawal and a disconnection from peers. The young person’s style of relating to peers reflects their negative thinking and the responses that are elicited are likely to reinforce the young person’s sense of isolation. This results in further social withdrawal, reduced social contact, and increasing disconnection from peers. These are the spiraling effects that occur during social interaction when a young person is experiencing depression, and the subsequent deleterious effects on relationships with peers. I have borrowed the phrase “spiraling effect” from Suzie as it provides an insight into the complexity of the impact of depression on the development or maintenance of a young person’s peer relationships, one of the key developmental areas during the transition to adulthood.
I have made the claim that the negative beliefs peers may have about mental health difficulties will also contribute to the disruption of peer relationships. When the young depressed person is experiencing negative thoughts and this results in social withdrawal or feelings of disconnection from friends, and peers hold stigmatising beliefs about mental health difficulties, the maintenance of relationships with peers is severely restricted.

By accepting that the development of relationships with peers is an essential part of the adolescent’s transition to adulthood, I suggest that the opportunity for a young person experiencing depression to continue on this pathway is also severely restricted. This final comment from Minny serves to draw all of these threads together.

Minny:

I locked myself away from everyone, even my boyfriend. I didn’t want people to see me, I hated myself, and I didn’t like hating myself but I didn’t know what was wrong. I’ve lost a lot of friends. In fact I’ve lost most of them. I stayed away for so long and by the time that I felt like seeing them again they had found out that I was depressed and they couldn’t deal with that, and I couldn’t deal with them, so now I pretty much don’t have any friends and I feel like I have to start from scratch and I don’t know how to do that anymore.

(vi) The Role of Peers as Supports

Not all of the friendships the young people had established were severed during the experience of depression, and for some of the participants, peers were viewed as considerable sources of support. The participants were able to identify how they found their peers supportive. Here are some examples: Tess’s experience of a supportive friend was someone who listened to her. The contact provided a distraction from her thoughts that she found helpful:
Tess:

You can have positive things in your day though, like I used to hear from my best friend and she was a real support to me and I felt like I could talk to her, and I knew I could ring her anytime. It stopped my brain from thinking and thinking and getting worse.

Emily’s thoughts on a supportive friend included someone who would not be offended by being asked to leave:

Emily:

You want a friend that knows you really well so that when you are feeling really bad you could just tell them to go home and they would understand.

Kathryn found it helpful when friends did not probe:

Kathryn:

I had some friends who were great. They didn’t ask lots of questions and they were just there for me.

Tess describes her boyfriend as supportive because he was there:

Tess:

Like because I had not talked to my friends for ages many of them had sort of stopped calling, but my boyfriend just seemed to hang in there. I must have been an absolute bitch to him, but he just hung in there, just was there for me.

The advice offered by friends was generally held in high regard by the young people as is described by the following participants:

Emily:

He asked me where I was going and I said to counselling and he said that he didn’t think you needed counselling, just good friends. I had to think about that for ages as I liked my counsellor, but I knew that what he was saying was right too.
Lachlan:

There was one mate who gave me some ideas about how to deal with it [depression] and I trusted him so I found him really good value.

(vii) Peers with Similar Experiences

For several of the participants, an important factor in being supported by friends was an acknowledgment that these people had also experienced depression. Here are two of the participants’ perspectives:

Emily:

I have met lots of people who after you have met them you find out that they have been depressed too. It’s like, I’m not the only person in the whole world.

Emily’s description provides an understanding of the importance of recognising that she was not unique in her experience, and was able to find relief in recognising that many other young people had also experienced depression.

Lacey offers a similar perspective, recognising that she had been unaware that she had found herself attracted to young people who had also experienced depression:

Lacey:

I didn’t have many friends at school but all the friends I did have seemed to be people that were depressed as well. It was like I was attracted to them for reasons I didn’t recognise at first.

I wanted to understand more about this attraction, and began to recognise that this was linked to a perception that young people with similar experiences were viewed as people who would “understand”. From the participants’ descriptions, I interpreted that this was based on previous interactions with young people who had experienced similar difficulties where the participants had felt understood.

This level of understanding could only be expected from people who had experienced depression, as is described in the following excerpts:
Minny:

I had met these guys at [the service] who had been depressed and they really understood me. We had a special bond right from the start.

Emily:

No-one could really understand what it's like to be depressed unless they had been depressed themselves, I know that from talking to mates who have been there [depressed].

Joe:

I have one friend, and I think he knew what it was like for me better after his Dad died and he was depressed then.

Another interesting finding described by several of the participants related to their tacit ability to recognise others who are depressed. How this happened was less easy to explain, however one of the participants described intuition as important to this process.

Ella:

She said to me she knew what it was like for me and I believed her, like I felt like I could talk to her. There was something about her, like I sort of intuitively knew that she had been depressed even before she told me. I don’t know exactly what it is. Maybe the experience changes you. Like you feel so bad about yourself that you somehow see other people who feel the same about themselves, or maybe its because you’ve met others that have had it too.

Lacey’s comments also describe this phenomenon:

Lacey:

Like it’s something about when you have been really depressed you can easily recognise other people who are depressed, and you know what it’s like so you connect with them in some way. I can go into a crowded room now and I could tell you pretty quickly who was depressed. Like it’s a
second nature to me. If I am with a friend who is depressed then I would have picked it long before I found out from them because if you have been depressed then you can pick it straight away.

This intuition may have developed through having heard what depression might “look like”, having had the experience themselves, and meeting others who are, or have been depressed. As an example, Emily was able to recognise that her partner had become depressed through noticing some of the experiences with which she was familiar.

**Emily:**

*R [partner] ended up at [a medical service for young people], and the doctor he saw put him on Prozac. Like it was good that I noticed the signs so that I could take him along there. He wouldn’t have gone there otherwise, so the doctor said it was good that I noticed so that R. could get help early. It will stop him from getting as sick as I was, I hope.*

I have identified the significance of relationships with young people who have had similar experiences. From an interactionist perspective I thought that it would be important to understand what would happen if these relationships faltered. Lacey’s comments provide an insight into this phenomenon:

**Lacey:**

*I had two close friends and we were all supports for each other as we all were depressed and had all been in hospital together. Then one of them killed themselves and the other one tried, so at that point I thought there was nothing left for me and I didn’t believe that anyone understood and there was no one there to give me the strength to carry on.*

In this excerpt, Lacey describes what can happen when young people with depression form attachments to other young vulnerable people who then become unavailable. My understanding of this is that their interaction with other vulnerable young people has held significance in the developing view of their
selves. The finishing of these relationships is a devastating experience as an important reference for their definition of self is no longer available.

(viii) The Phenomenon of Peers Reducing Support over Time
The participants were able to describe other relationships where change occurred over time. Some of the participants described recognising the difficulty for others in supporting a depressed young person in an ongoing way, accepting that the average period that this support would be required may stretch from months to years. The following comments allude to a gradual reduction of the support that is offered by peers:

Minny:

Some of them were good at the start but after a while they stopped ringing me and talking to me after school. I guess they must have gotten sick of it and thought that I was always going to be like that.

Suzie:

When she first found out it was fine, but then she seemed to get more pissed off with me, and after flatting with her for a few months she told me to 'get your bloody act together, what the hell are you doing to me'. It destroyed me.

Kim:

I think that after a while it just gets boring for them and that I'm just using them for support. Like what kind of a basis for friendship is that? They feel sorry for me and I need help.

The participants identified that over time their friends lose their tolerance for offering support and they distanced themselves, severing the relationship. Kim identified that she had changed her group of friends, and related this to her new friends not having reached their threshold of frustration:

Kim:

I've found that I've changed my group of friends since I've been depressed. Like both groups have been supportive but
Kim implies that her new friends are continuing to provide support, although she expects that they will reach their threshold of tolerance soon, describing this as though it was an inevitability, further supporting my suggestion that friends are likely to reduce support over time.

An explanation for the reducing support from friends over time relates back to my earlier comments on the nature of adolescent friendship. Peer relationships during adolescence are often intense, although brief in nature, becoming more stable throughout the transition to adulthood (Berndt, 1982; Bradford Brown et al., 1997; Hartup, 1983). Mental health difficulties such as depression interfere with aspects of the transition to adulthood, an example being the impact on peer relationships, although the exact mechanism of this disruption has been inadequately researched (Bradford Brown et al., 1997).

The young people in this study were at the time of the interviews, older (chronologically), adolescents. The literature suggests that the reliance on peers and the emotional detachment from family occurs over a period of years. If we refer back to the two year study of 1300 adolescents, Brown et al. (1986) found that the importance of peer group affiliation declined throughout the adolescent years. Younger adolescents favoured the ability of the group to provide emotional support, foster friendships and facilitate social interaction. Older adolescents favoured smaller more intimate established relationships and were dissatisfied with the demands of conformity.

The nature of the changing relationships with peers when a young person is experiencing depression suggests to me that compared to their friends, their developmental process has been interrupted, and therefore their development is no longer synchronised to that of their peers. Whilst their peers are moving
towards increasing levels of intimacy in smaller groups of friends, the participants described increasing isolation from all friendships.

When a young person is depressed and therefore potentially experiencing a delay in the transitional process to adulthood as my research increasingly suggests, my interpretation is that it is likely that their peer relationships will be disrupted. Depending on variables such as the health status of their friend(s), the young person and their friend(s) would be effectively undertaking a maturational process at significantly different rates, creating frustration for one or all of the young people involved, and placing stress on those relationships and their future.

(ix) The Role Of Acting

From the participants' descriptions it appears that a part of the difficulty for peers in supporting depressed friends rests in the difficulty in understanding how a young person is feeling when they are acting as if they are fine. This confusion related to young people acting was also described by parents or caregivers (Chapter Three), and in Chapter Five, exploring relationships with health professionals. Here are some examples of acting where peers are the recipients.

Suzie:

Like I guess it's my facial expression. If I'm not feeling comfortable I'll try and smile to show a reaction and deep down I'm feeling terrible and they are thinking that I'm happy as Larry. An example is what I do when I'm new. Like when I started at [high-school] I was really depressed then, but I pretended that I was confident and happy, but I couldn't keep it up and I just got more and more uneasy with it all.

Emily:

My friends would ask me how I was and I would say that I was good and hope that they wouldn't ask anymore questions if I pretended that I was fine.
Suzie and Emily offer different reasons for acting when in the company of peers: Suzie to impress upon new acquaintances that she was “OK”, and Emily to prevent others from asking too many questions.

One of the problems with acting was described as the amount of energy that is required to sustain this activity, and therefore the difficulty experienced in maintaining this pretense. Tess explains:

*Tess:*

*If I had met people then, like friends on my course, who didn’t know that I was depressed, then I don’t think that they would believe me now when I told them. I used to just put up this front all the time, and when I ran out of energy for it I would just go off on my own and they wouldn’t see how I felt. Like it makes you physically tired, and in the end I couldn’t do it anymore.*

For some of the participants their attempts at acting were recognised by their friends. Ella links this with her reduced energy:

*Ella:*

*You need to put on a happy face because otherwise you get asked so many questions and yeh, you don’t feel up to that so you just pretend that everything is OK, but it gets harder to do that, and even when I thought I was managing it, the friends that knew me well would tell me that I was spending a lot of time looking ‘out of it’ and staring into space. And sometimes I just didn’t have the energy to act so I would stay away from people at those times, like just sit in the library or something.*

What is revealing from Ella’s description of her attempts at acting is that despite her attempts to hide what was happening to her, her friends were able to recognise that something was different. This suggests that acting may be more transparent than some of the participants believed.
As a final comment on the functions of acting when with peers, for some of the participants, acting served as an attempt to distract themselves from their experience of depression. Here are two examples of this:

**Lachlan:**

_I used to try and pretend to myself that everything was fine, and did this when I was with my mates, but it was a very temporary thing, and I think it made me feel worse when I realised that I was such a failure I couldn't even pretend that things were good._

**Kathryn:**

_I used to pretend that I was fine when I was with my mates and I would be thinking that I was OK, like trying to trick myself, but it always made things worse._

Once again the effects of depression on a sense of self are noted from an interactional perspective. For example, when attempts at acting as if they were fine when with their friends were unsuccessful, the young people felt that they were failures, thus reinforcing their sense of self-worthlessness.

(x) **Other Aspects of Depression and Peer Relationships**

- **The meaning of self-harm and suicide to participants and their peers**

Thoughts of self harm and suicide are closely connected with the experience of depression (Goldney, 1998; Horwood & Fergusson, 1998). All of the participants in this research had experienced suicidal thinking and several having acted on these thoughts. I have often wondered how young people perceive others who are experiencing suicidal thinking, the literature suggesting that suicidal thinking is not uncommon during adolescence (Horwood & Fergusson, 1998). I have included information here that examines how the topics of suicide and self-harm are perceived by young people, especially where one of their peer group is experiencing these thoughts when depressed. The first description offered by Emily identifies the significant presence of thoughts of suicide amongst young people:
Emily:

I think that nearly all kids at school think about suicide at some stage or other. Like most of the kids I know have talked about it. I guess that’s different from doing something, but I think you would know when they were serious about hurting themselves.

When I explored with Emily how she would recognise when a friend was ‘serious’ about harming themselves, Emily offered the following:

Emily:

Well I guess they would be different to how you usually knew them, like really depressed or talking about suicide in a way that would make you think like they were thinking about it for themselves, like really hopeless about their situation.

Emily’s thoughts on hopelessness as being an indicator of suicide risk were echoed in Suzie’s comments which highlight her thoughts on the sense of hopelessness young people experience. Hopelessness has also been recognised as a key indicator of suicide risk by the Canterbury Suicide Project (Beautrais, 1998). Suzie also describes a range of activities which to her, are suggestive of thoughts of self destruction:

Suzie:

I believe now that lots of people that I know, like people at school, have suicidal thoughts, but they express them in different ways. Maybe it’s by trying drugs and alcohol, or maybe it’s by driving fast or walking the streets in town by themselves at night. I think that none of them care about the future much, or maybe they feel really hopeless about it.

The range of activities that were indicators of self-destructive behaviour by Suzie are well documented as potentially health compromising in the literature (Bradford Brown et al., 1997) but would also be included in the behaviours that might indicate normal adolescent experimentation, often a part of the peer experience on the pathway to adulthood. The difference is described on a
continuum of the dangerousness of these behaviours, and the presence of other contextual factors that might indicate a propensity for self-harm. Another factor to consider is the danger of young people communicating their thoughts of self-harm to other young people in a manner that suggests that suicidal thinking is an acceptable part of adolescence. If through this thinking young people view expressions of suicide as acceptable, they may be unaware as to when another person is potentially at risk to themselves.

An area related to the participants' potential for bodily alteration resulting from self-harm was self-mutilation. I was interested in the participants' perspectives of these behaviours in relation to their peers.

Some of the participants identified self-mutilatory behaviours that occurred within a peer group setting which at face-value would be difficult to distinguish as behaviours indicative of self-destructive thinking. Emily's comments offer an example of this phenomenon:

**Emily:**

*Like there was stuff you had to do if you wanted to be in the in crowd, like that blood brothers and sisters stuff, cutting your finger or arm with your friends, you had to do it or you weren't cool.*

During my contact with young people in their school environments the presence of self-harm activity is common, and often not clearly linked to self-destructive thinking. The literature suggests that self-injury is a broad term which describes direct actions that harm the body and are outside the realm of social and cultural acceptability (Connors, 1996; Walsh & Rosen, 1988). There are many forms of injury directed towards oneself that are socially and, or culturally accepted yet may result in bodily alteration. Examples are body piercing, tattoos, the use of alcohol or other substances, or playing hard contact sports, yet none of these activities would necessarily be described as intentional self-injury. The key to understanding self-injury is knowing the context in which it occurs (Connors, 1996; Martin, 1997). Tattoos may represent the quest of a young person to keep
abreast with peer fashion or alternatively might describe the distress connected with significant intra-family disruption (Martin, 1997). It is also important to consider that self-injury may be described on a continuum. Peers demonstrating their bond through joining in "blood brother" rituals is at a different point of the continuum to young people who regularly cut themselves in order to relieve tension, sometimes requiring medical intervention, in a context of significant past trauma. Determining self-injury must involve a consideration of the cultural context in which it occurs (Connors, 1996).

The participants were able to identify that many self-mutilatory behaviours could be determined as an acceptable and important part of youth culture. As the behaviours became more solitary and less a part of the group experience, they were considered likely to be linked to mental health difficulties. Here is an example from Suzie:

**Suzie:**

I'd probably want to punish myself because I hated myself, so I would stay away from everyone. I used to think my face is just disgusting, I guess the whole day could go by and I'd just absolutely attack my own skin kind of thing, and then I would think, oh now I have to hide away so no one would see me. It meant I couldn't face anyone.

Whilst Suzie describes her self-harming activity as a way of punishing herself connected with her self-hatred, engaging in this behaviour meant that she was unable to spend time with her peers, increasing her isolation. Tess also articulates this phenomenon in her comments:

**Tess:**

I used to scratch my head until it was raw. It was so sore, and pretty obvious, that I stopped going out with my mates because of it.

Not all self-harm activities that the participants engaged in were alone:
Lacey:

Well I never knew much about it until I met J. and T. in hospital. They started it by showing me how to cut, but in the end it was me showing them how to burn, like you use hairspray. Well you spray it on your skin, I used to spray it on my arms and on the top of my legs, and then you light it with the lighter, you watch the burning, and I think it's a combination of watching plus the pain and the smell that gives you such a buzz.

Lacey describes that the cutting and burning behaviours commenced during her hospitalisation, this being an admission as an adolescent to an acute adult psychiatric unit. The literature suggests that young people admitted to psychiatric units who have not previously engaged in self-mutilary behaviours may well be introduced to such behaviours during their admission, often by peers, and commence such activity (Hartmann, Glasser, Greenblatt, Soloman & Levinson, 1968). Lacey’s choice of cutting and burning behaviours are very common amongst people engaging in self-mutilation (Briere, 1992; Connors, 1996; Jones & Daniels, 1996).

Self-mutilation is commonly attributed to people who have survived abuses of emotional, physical and sexual types as children (Briere, 1992). Jones and Daniels (1996) suggest that inadequate parenting resulting in isolation is a common variable reported in the life histories of people who engage in self-mutilation. They propose that the associated feelings of isolation and abandonment are important factors in the development of these behaviours, and that they are associated with:

An experience or threat of loss or abandonment or an impasse in interpersonal relations. The most common associated emotion is unbearable tension which is relieved by the self-mutilation (Jones and Daniels, 1996, p. 265).

Self-mutilation is therefore considered in an interpersonal paradigm, isolating the participants from their peers who had not experienced mental health
difficulties, whilst connecting some of the participants with other young people with similar difficulties.

- **Self-harm and drugs and alcohol**

Another related area that I explored with the participants where peer relationships featured in the analysis was the use of drugs and alcohol.

Drug and alcohol use often commences during adolescence within peer settings, and for most young people this will remain at a level of experimentation only and not lead on to longer-term difficulties. The literature suggests that use of alcohol or drugs by young people experiencing depression may be associated with an attempt to improve mood (Khantzian, 1985). A further finding from the reviewed literature suggests that owing to the disinhibiting effects of alcohol and some other drugs, the risk of impulsive behaviour during intoxication might place some young people at risk of self-harm (Shaffer, Garland, Gould, Fisher & Trautman, 1988). The literature also suggests that when young people experience mental health difficulties such as depression where social withdrawal may occur, they limit their chances of joining ‘high status crowds’ (Bradford Brown et al., 1997, p.175) and are more likely to be accepted into fringe groups where there may be an increased use of drugs and alcohol.

I was interested to explore with the participants whether they perceived any connections between their substance use and depression, and gain their perceptions on how their choice of peers may have contributed or otherwise to their drug or alcohol use.

The young people in the study were able to identify connections between alcohol and drug use and depression, and as a result had made decisions around their choice of peer groups. Here are some examples:

**Emily:**

_Yeh, I am different now. The other thing is that I don’t take as many risks now. Like I don’t get into fast cars with drivers that I’m worried about, and I don’t do drugs_
anymore. Like I wonder if it was that sometimes that stuffed me up. Like I’ve smoked marijuana a few times and sometimes I think that it may linger in your brain and cause stuff like depression. Like you feel so mellowed out when you’re stoned, and you listen to all this bad music, it makes you really negative. Like I can’t talk to my friends about this because they believe that you can give up at anytime, and I’m not sure that’s true for me. So it means I have to stay away from some of them or I feel hassled, but it’s hard finding friends who will accept you when you’ve been into that scene.

Kathryn:

I used to smoke dope and drink a lot when I was about 15 and I was a real mess then looking back, and I don’t have those friends anymore, and that’s good because that makes you even more depressed.

Lachlan:

I used to get into all of that shit [drugs and alcohol] and I think it was to escape, but I think that it probably made me more down. I had to move out of that place so that I could be with others who weren’t so into that scene, but it wasn’t so easy to just find mates that weren’t into that stuff, the guys that weren’t into the shit scene didn’t feel OK with me.

The recognition that to stop participating in certain activities such as drug taking required changing peer groups is further testament to the influence and power held by these groups. A young person would find it difficult to make different choices to others within a group. The literature suggests that because of the strong identities that peer groups develop, movement between groups is difficult and would be regarded suspiciously (Bradford Brown et al., 1997). This may account for the reason Emily and Lachlan have struggled to move into a new peer group.
A study by Bradford Brown et al. (1997), indicated that it would be easier to move between peer groups that practiced health-compromising behaviours than to others. This perhaps explains why young people experiencing depression would find it easier to move to a peer group where activities such as drug and alcohol use were a part of the group’s identity. This finding, which is consistent with the suggestions made by Bradford Brown et al. (1997), describes how depression may have an impact upon peer relationships, and why it might be difficult to emerge from depression without being socially compromised, further affecting the transition to adulthood.

(xi) Getting Better, Changing

The final area of this chapter explores the participants’ experience of recovery from depression and expands upon the previous discussion on the effects of depression on peer relationships. My interest in pursuing this area relates to my understanding from the literature that peer relationships provide an area to practice relationship development in preparation for adulthood (Brown et al., 1986; Coleman, 1993; Hendry et al., 1993; Lloyd, 1995; Ochiltree, 1990; Wyn & White, 1997). How then do young people describe their relationships with peers when depressed?

To begin this discussion, here are some comments on how young people and their friends perceived a recovery from depression. Kim’s description elucidates her strengthening sense of self during recovery:

Kim:

*I think that I’ve changed as I’ve gotten better. I have a more defined personality now and I think it’s one that people react to more in either a positive or a negative way. When I was depressed it was like my personality was suppressed and all other people saw was this bland, quiet and reserved person that they couldn’t relate to. I’m sure this has changed because I’ve been depressed. I’m more*
like I was before now, but I don’t think I’ll ever get back to the person I once was.

Ella’s description of how she was perceived by friends is as follows:

**Ella:**

*And they would say that it was good to have Ella back, like they would say that I’d been there physically, but like I had not really been there at all.*

Minny identifies that she has changed her peer group during the time she has been depressed:

**Minny:**

*I’ve really found out who my mates are, and it’s certainly none of the mates I had before I was depressed.*

For some of the participants, their changed ability to interact that they associated with recovery led to a re-evaluation of established relationships. Emily and Ella provide an insight into this area:

**Emily:**

*Yeh, when I was really depressed I really liked it when R. [partner] would just sit with me all day. Like he likes that kind of life anyway. But now I want to go out and do things and he still wants to sit on the couch. Like I’ve changed and he’s stayed the same.*

**Ella:**

*I don’t see so much of them now, it was like I needed them then and they were prepared to stick with me, but now I think that’s changed and I need them less, but they still want to help me and it’s like, hard to get them to see that they don’t need to.*

Emily and Ella’s descriptions show that recovery from depression is a dynamic process and peers may not be either aware of, or able to accommodate to the changing needs of the young person recovering from depression.
For some of the participants, a measurement of their improvement occurred by way of meeting other young people experiencing depression. Emily offers a description of this:

Emily:

_I was in the waiting room at [the mental health service] once and I saw this girl with her head down, not reading the magazines or anything, and kind of staring into space. My Mum asked me who it reminded me of, and it wasn't until then that I recognised how much I had changed. So I think it's good to meet other kids your age when you're depressed so that you know where you are and if you're getting better._

Emily’s comments explain the importance of peers during the young people’s experience of depression. For example, evaluating her recovery was achievable through an interaction with a peer experiencing similar difficulties. To me, this offers information that can be used to consider the types of support that are best suited to a young person recovering from depression.

4.3: Summary from Chapter Four

_The Effects of Depression on Relationships with Peers_

Depression interferes with the development of relationships with peers. This is demonstrated by disconnectedness and physical withdrawal, and a difficulty in re-establishing relationships during recovery from depression. These effects result from the impact of negative thinking on a young person’s sense of self. A negative sense of self is reinforced during a young person’s interaction with others. Young people develop social competence through social interaction. Depression interferes with this process. As social competence is required for the transition to adulthood, it follows that a process such as depression potentially interferes with the transition to adulthood.
How Depression Influences Relational Dynamics with Peers

- **Difficulties in telling peers about depression**
  Young people perceived that telling their friends about depression might not be helpful as friends may not feel comfortable with this knowledge; they might not understand and would therefore view them differently, or that the relationship would then be based on pity as their friends may feel sorry for them.

- **Recognising depression in others**
  Other young people also experiencing depression were viewed as understanding and therefore provided an attraction for the young people in this study. This would often occur before finding out that these people were also experiencing depression, suggesting an intuitive understanding.

- **The hazards of acting**
  Friends could be confused about the severity of a young person’s experience of depression as the young person would use acting to pretend that they were fine, but could not sustain this over a long period.

- **Changing peers to reduce alcohol and drug use**
  The use of alcohol and drugs was viewed by the young people as connected with their depression, and to avoid substance use, peer groups would need to change, a difficult task when a young person is experiencing depression.

**Peer Support**

- **Peers are/can be supports**
  When the participants were depressed, friends were helpful when they offered a non-intrusive presence, which was also described as important in their relationships with caregivers. Additionally, advice from friends was held in high regard. I view this as an indicator of the importance of relationships with peers during adolescence.

- **Sharing thoughts of self harm and suicide**
  When young people are depressed, they may experience thoughts of self harm or suicide, particularly following stressful events such as relationship breakdowns. They may confide these experiences with their peers.
• **Peer support has limited existence**
  The ability of friends to sustain their support over months or years was limited and the young people acknowledged that they tended to lose friends as their depression continued.

• **A changing sense of self during recovery and the effects on peer relationships**
  The young people noticed changes when they were recovering from depression. Examples of these changes included recognising that they felt more decisive, confident and energetic. They were able to enjoy contact with peers again and felt more socially active. As some relationships had been based on a one-down dynamic when the young person was depressed, an improvement in mood sometimes led to conflict when the other person could not accommodate the changes that accompanied recovery. Additionally, most of the young people identified that despite their recovery, they felt that they would always be different for having experienced depression, and this would be reflected in their relationships.

*Messages for Peers; Intervention Strategies*

**Peer based strategies. Information, education and support for peers providing assistance**

• As depression interferes with the development of relationships with peers which may have associated consequences on the process of individuation, peer-based interventions should be included as a part of any intervention strategy. This would avoid a significant loss of peer relationships and the resultant social isolation and disconnection that potentially diminishes the opportunity for a return to a style of social interaction experienced before depression. Examples of interventions would include the education and support of peers promoting their ability to support a young person experiencing depression.

• If young people chose to change their peer group in order to avoid alcohol and drug use, they would need considerable support in this process.
Establishing new friendships during adolescence can be difficult owing to a fear of rejection, and is more complicated when a young person is experiencing depression as their ability to interact socially is compromised.

- By providing an education programme which focuses on mental health and mental health difficulties and incorporating this into a school curriculum, the stigmatising views young people hold on mental health can be challenged and addressed.

- The young people identified that a non-intrusive presence was important in the relationships between both peers and caregivers; and young people experiencing depression. This information could assist friends and caregivers to provide support that is seen as positive, and does not require a significant level of interaction.

- From the information that advice from friends was held in high regard, friends could be viewed as being able to provide a gateway for young people experiencing depression to access a range of interventions. To explain this, friends are often the first point of contact chosen by a young person experiencing depression, and if the friends hold relevant knowledge on support options, they would be able to facilitate access to a range of supports.

- As events such as a relationship breakdown can lead to suicidal thoughts when a young person is experiencing depression, it is important for peers to be aware of the potential effects of such events. They must be supported to break confidence if their friend confides thoughts of intentional self-harm, and to offer support and access to other supports at these times.

- The ability of friends to sustain their support over months or years is limited and young people lose friends as their depression continues. The loss of friendships is inevitable when a young person is depressed over a long period of time. I suggest that:

  (i) young people need to know how to support themselves when supporting friends with mental health difficulties. Such strategies can be introduced by health professionals such as school-counsellors or by teachers within the school setting;
(ii) young people experiencing depression must be supported when friends are no longer able to offer support, and as earlier identified, interventions that support and build on a young person’s social skills must be a part of any intervention strategy.

- As acting is one of the behaviours a young person experiencing depression uses during their interactions with others and friends find this confusing they need to be supported to make sense of these behaviours.

**Recognising depression in others, an opportunity for early intervention**

- If people experiencing depression are able to identify others with similar experiences, they could be supported to facilitate access to earlier assistance for these people.

**Concluding Comments**

This chapter has explored how young people who have been depressed interpret and describe the changes in their peer relationships resulting from this experience. Their descriptions highlight an altered ability to interact with peers which results in a sense of loss of control and powerlessness as the course of these relationships change.

The young people also described the effects of the stigma attached to depression held by themselves and their peers. This precipitated a social distancing, and contributed to lowered self-esteem.

We have heard that from their perspectives, the changes they have experienced as a result of depression have re-shaped their experience of peer relationships during adolescence, some of the young people articulating their different selves as a result of this process. Yet again we are informed about the impact of depression during adolescence from an interactional perspective, highlighting the resources young people experiencing depression draw upon in order to survive.
CHAPTER FIVE: RELATIONSHIPS WITH MENTAL HEALTH SERVICES AND HEALTH PROFESSIONALS

I've stopped saying, "OK, I'm going to get over this depression...". I did buy into the pursuit of happiness and the pursuit of fulfillment. I hate that word. And the mental health equivalent to finding fulfillment is finding the gaps inside of you and everything grows green (Female, aged 27. In Karp, 1996, p.74).

5.1: Introduction to Chapter Five

What do young people think about their contact with mental health professionals [clinicians] and their attendance over time at a mental health service? Do they have positive experiences that would encourage their further contact if this was required, or are they as cynical or frustrated by their experiences as the quotation above suggests (Karp, 1996)? As I mentioned in Chapter Two, my experience of being a clinician working with people experiencing mental health difficulties for 23 years is that I have a measure of faith in the delivery of mental health services. However, I also believe that more can be done which explains my interest in exploring this area with the participants in this research. This chapter seeks to elucidate the participants’ experiences of attending a mental health service and their contact with clinicians.

The Participants and their Contacts with Services: The Demographics

The participants’ attendance at the youth mental health service ranged from between four months and two years. The majority had also been in contact with other services, for example, an emergency psychiatric service (a 24 hour service for people requiring urgent or immediate intervention where there are mental health concerns), or child and youth community-based mental health services. Four of the participants had experienced hospital admissions, these being to acute adult psychiatric units. All had been medically diagnosed with depression.
using the DSM-IV (APA, 1994) schedule during their attendance at the mental health service.

**The Data Collection Process**

The interviews developed from a set of questions that were chosen in the hope that they would encourage open comment from the participants on their experience of being “diagnosed” with depression and their attendance at mental health services (see Chapter Two). However, the participants required little encouragement to discuss these experiences. Interviews with the young people and their caregivers provided me with many examples of their thoughts and beliefs about mental health services and treatment. As I am employed as a clinician at the service the participants attended I was able to draw on my knowledge of the organisation and operation of the service and this was also included as data.

**The Analysis**

The many descriptions of the participants’ and caregivers’ experiences of attending mental health services that were found during the coding and categorisation of the data enabled an interpretation of how the participants’ perspectives had developed through their interaction with others.

As has been highlighted throughout this research, one of my main areas of investigation has been the concept of stigma and mental health difficulties. A finding from the literature that has been identified in Chapters Three and Four is that self-worthlessness is commonly described as a feature of depression and is linked to experiences of an altered self-concept and lowered self-esteem (Beeber, 1996; Olen, 1993). As discussed in the literature (for example: Dunnachie-McNatty, 1995; Goffman, 1959; Laing, 1967) the effects of stigmatisation on people experiencing mental health difficulties such as depression may be harmful and further disadvantage these people (see Chapters One and Two). If a young person’s perception of self has been affected by depression they may be more vulnerable to the stigmatising beliefs held by others or themselves.
Therefore, an analysis of the participants’ descriptions identifying self-concept, self-esteem, or identity, was important in order to understand their ability to manage any perceived stigma.

### 5.2: Relationships with Health Professionals and Mental Health Services: The Findings

This chapter provides one of the key opportunities to explore the ways in which young people describe their experience of mental health services. This information is presented in two main areas: perceptions of mental health services and relationships with clinicians.

#### 5.2.1: Perceptions of Mental Health Services

**A Focus on Geography and Architecture: The Physical Location, Pre-conceived Ideas About Psychiatric Hospitals as ‘Scary Places’**

The mental health service is located on the grounds of a psychiatric hospital built in the late 1800’s. For me, the unique gothic-style appearance of the hospital has engendered a sense of mystery and intrigue for the 20 or more years that I have been acquainted with this institution. Visions of yesteryear and draconian psychiatric practices dominate my thinking when I am confronted with the architecture of this establishment. My visions of times-past remain the legacy of both media representations and verbal interactions I have held with older staff who were able to recall some of the earlier practices of “caring” for people with mental health difficulties.

I was interested in hearing what the experience of attending a mental health service located near the remains of an old institution was like for the participants. Phelan, Bromet and Link (1998) suggest that mental health services situated in older psychiatric institutions are more likely to attract stigma on account of their architecture, and people’s associated beliefs about the patients who may have been accommodated there. In my work at the youth
mental health service there has been ongoing discussion concerning the positioning of the service and the extent of the stigma the local community has attached to this.

The literature suggests that it is not always the experience of mental health difficulties that people describe as being difficult. Often the experience of attending a mental health service can be more challenging owing to the perceived stigmatisation (Miles, 1984; Rosen, 1985; Teasdale, 1987). A clinical study by Teasdale (1987) found that people who were attending mental health services reported that they had attempted to conceal their illnesses for as long as possible in order to avoid contact with these institutions on account of their perceived stigma. The researcher felt that by creating a delay in receiving treatment, the mental health of their participants was compromised further.

During the interviews, I explored the young people’s impressions of mental health services prior to their contact. Some of the terms used by the participants and caregivers included “scary”, “awful”, “loony” and “psycho”. I suggest that this greatly influenced their experience when they discovered that the mental health service for young people was on the same property as a psychiatric hospital. Here are some examples:

**Emily:**

They [the emergency service staff] told me that it was the [mental health service], but they didn’t tell me that it was at [the psychiatric hospital]. Like they gave me a map, but I didn’t know that it was at [the psychiatric hospital]. I wouldn’t have come.

**Trina, mother of Emily:**

Before we found out that Emily was depressed I’d heard some of her friends talk about ‘psychos’ and ‘loonies’ when referring to [the psychiatric hospital]. It even looks scary. I can’t imagine what it must be like for a young person to be
going there for the first time, I saw Em's face drop when she saw the hospital and I felt for her.

**Damien:**

*I thought that those were places for psychos.*

**Kathryn:**

*I believed that you really had a screw loose if you needed to go to one of those places.*

**Tess:**

*I used to think that you would have to be really nuts to need to go there [a mental health service].*

Such comments support the argument that negative images of mental health services promote the stigma that is reportedly attached to them, advancing views that mental health services are to be avoided.

- **Negative images of mental health services and the media**

I continued on to explore with the participants where they believed that the negative images of mental health services had developed. Suzie offers her comments in this area:

**Suzie:**

*From the damn ole place, the institution. It looks like [an institution for people experiencing intellectual difficulties], doesn’t it? You know, they can’t cope in the community, it’s all that unknown stuff. Like, we had relatives that had been in [a psychiatric hospital] and Mum had tried to get us to go and visit them with her, but we never did because it was scary, you just learn socialising as kids that you don’t go near that place, and you don’t talk about it if you have been.*

These comments from Suzie describe the belief that she had earlier held that psychiatric hospitals are scary places. Such an interpretation was constructed by her conversations with others about the place of psychiatric hospitals outside society. Similarly Emily ascribes a scary image as one portrayed by the media:
Emily:  
You would probably have ideas about it that you got from television or something like that, you know, when you see those really scary people in hospitals, like in the old movies.  
That was true for me anyway.

These comments from Emily highlight the influence of media such as film on the beliefs and attitudes of people regarding mental illness. Other participants also attributed community impressions to the media:

Joe:  
I think it's from those movies like that 'cookoo's nest' one.

Kathryn:  
One of my mates told me about this movie where they were in this loony place with straight-jackets, and I thought that that was what it was like. And you read about those people who kill their families; spooky.

Ella:  
I think those ideas came from the movies, I saw this old video once where there was this awful mental place where these people who were really out of it just walked in circles all day, and I thought that that was what it was like.

The literature supports the participants' views that negative attitudes attached to mental health difficulties and mental health services are promoted by the media (Ashmore, 1975; Rosen, 1985; Waite, 1985). As Rosen (1985) suggests, through its everyday coverage, the media reinforces negative attitudes, often using sensationalism in an attempt to increase sales. When negative attitudes are reinforced, a culture of non-acceptance and discriminatory behaviour is encouraged.

- **Changing views during attendance**

Despite the participants' beliefs about mental health services prior to their attendance, they described that these views changed once they had commenced
attendance and became more familiar with this environment. Here are some examples:

**Emily:**

"After a while of going there I thought that it wasn’t so bad and I basically just got used to the place. People were friendly enough."

**Ella:**

"I personally didn’t have a problem with going there after a while. You see other guys there who have the same problems and you realise that you’re not the only one."

**Lacey:**

"You get used to it I guess. You see people who remind you of you."

**Lachlan:**

"Yeh, I got cool about it. You meet some cool people there, like a guy from school who I wouldn’t have picked that he’d need to go there."

These comments support the notion that people that view themselves, or are viewed by others as being in a deviant group, are relieved to recognise that they share aspects of their deviant status with others experiencing similar difficulties (Tannenbaum in Gove, 1975, p.4). They feel that they are not alone. It seems reasonable to suggest that this identification with others promotes a protection of the young person’s self-esteem. These ideas are consistent with the literature that suggests that there are a number of protective and non-protective factors that will influence how a person experiences being part of a deviant group. Protective factors include:

- attributing negative feedback to the group rather than the individual;
- comparing an individual’s outcomes to the group rather than relatively advantaged others;
- selectively focusing on the positive aspects of themselves and the group;
- the presence of social supports and ambivalent feelings towards those delivering the prejudice (Crocker & Major, 1989; Gergen & Jones, 1963).
Some of the non-protective factors having a negative effect on self-esteem include:

- the length of time since the disability was acquired (the later acquired, the lower the self-esteem as the person has had less time to get used to the disability);
- concealability where the more obvious the disability, the greater the stigma attached (Jones, Farina, Markus, Miller & Scott, 1984; Weiner, Perry & Magnussen, 1988).

The participants belonged to three groups that increased their chances of stigmatisation: they were adolescents (see Chapter One), they had been diagnosed as being clinically depressed, and they were attending a mental health service. Recognising that they shared their experience with others who also attended a mental health service contributed to their increased acceptance of the service. Despite these changed views, their knowledge of the beliefs held by others about mental health services remained a deterrent to telling people such as friends and peers about their attendance. In other words, the participants recognised that their beliefs regarding psychiatric institutions as places that house mad people, psychos and loonies may have been shared by their friends who may be viewing them in this way. Even if their own ideas changed after they commenced contact, the participants remained concerned about the ways they would be perceived by others:

**Kim:**

_I wouldn’t tell many people about going to [the mental health service] as they might find out that it was at [the hospital] and then they would think, ‘oh, what a loony’. Like they would think that everyone there wore straight jackets or something._

**Lacey:**

_Heaps of people wouldn’t be able to handle it, so I’m pretty selective about who I tell._
Damien:

There's no way that I would tell my mates, they would think that I was an absolute nutter.

To complete this discussion, Kim describes what happened when she was less selective about who she told that she was attending a mental health service:

Kim:

Yeh, I didn’t care who I told at first and I thought it was important that they knew, like I thought that being honest was best, but I found out really quickly that that wasn't the case and that even some of my friends couldn’t deal with it at all. I felt worse and even more alone. I heard things like; 'She’s going to that psycho place so she must be really psycho'. I wasn’t just imagining that they were talking about me at school, they really were, and I felt like shit.

The experience of isolation and devastation that Kim describes informs the notion that the stigma that is attached to mental health services influences the experience of people who attend them. I interpreted from Kim’s description that the discrimination from her peers had a negative effect on her self-esteem made transparent in such comments as 'I felt like shit'. The negative comments from peers about her attendance at a mental health service had potentially compromised her mental health further.

My understanding about the participants’ decisions not to tell friends is that they were acting to protect themselves from a further assault to their self-esteem. This area extends the discussion in Chapter Four, on relationships with peers.

5.2.2: Relationships with Clinicians

**Impressions of First Contact: The ‘Assessment’**

- My clinician perspective

The first contact at the service is described by service staff to clients and their families as an initial assessment. This is a time when the clinicians at the service
gather information in a number of areas that assists them to deduce the nature and the extent of the mental health concerns. From my clinician role, I was aware that the average time for the first contact is approximately two hours. My interest in exploring this area relates to the connection that young people have with this process, and the likelihood (or not), that the information that clinicians will be offered will be representative of the young person’s position. This is of importance in recognising that the information from the first contact will influence the diagnosis a young person is given, and the treatment that follows.

- **Participant perspectives**

Here are some of the participants' views on this process.

**Suzie:**

> It seems like a long time ago. I remember feeling sort of removed from it. There were tons of questions, but I understand now why I was asked them.

**Ella:**

> I was just detached from it, answering questions like a robot. I don't remember much about it.

**Kathryn:**

> I remember first thinking that I would have to watch what I said as they would put me away or something, and I didn’t want to be there.

**Joe:**

> The first time I had to go through that assessment thing I just didn’t care and I told them what I thought they wanted to hear so that I could get out of there.

Explanations for this indifference might include:

(i) The participants’ concerns at attending a mental health service and the stigmatising beliefs attached to this.
(ii) Their feelings of disconnection and disempowerment by a process that they had not requested and did not want. Therefore, at the point of first contact they were attending with a degree of reluctance.

(iii) Their experience of depression. The young people made many references throughout the interviews of the withdrawal, detachment and “not caring” they experienced when depressed. This was frequently described in the context of relating to all others including caregivers, peers and health professionals, and may account for their perspectives of the first contact at a mental health service.

Another impression of the process of initial contact is offered by Lacey who highlights her experience of being involved in the initial interview process on a number of occasions. This occurred as she had been in contact with a number of services over a two month period, all of whom used a similar structure for interviewing.

Lacey:

When I first went to [the service] it felt like I had told everyone, then told everyone again. It was like no one believes you and you have to keep telling a story in case it changes or something. You just about know what the questions are going to be!

Lacey suggests that during her contact with a number of mental health services, the well-worn process of interviewing had led her to believe that she may have been being tested to ensure that she was not choosing to misinform clinicians of her position. Such a process potentially interferes with the development of a trusting relationship as is indicated by one of her later comments:

Lacey:

It took me a long time to feel OK with the interviews, like I didn’t really trust the whole thing when I was repeatedly asked the same things over and over.
The Diagnosis: Initial Reactions to Finding Out (That They Were Recognised as Being Clinically Depressed)

At the end of the process of initial assessment the young people were told by the clinician(s) that they were clinically depressed using the DSM-IV (1994) diagnostic schedule. I wanted to explore what this was like for themselves and their caregivers.

I knew that the clinicians at the mental health service supported the use of diagnostic labels. They would argue that treatment can only be informed by diagnosis. Furthermore, if there are negative consequences that occur for people as a result of diagnosis, their belief would be that these are outweighed by the benefits of appropriate treatment.

The DSM-IV was developed by the American Medical Association (1994), and is now offered in a fourth edition. It is used in all New Zealand mental health services, alongside many other western nations. The schedule provides a guideline for medical practitioners to categorise mental disorders in order to develop treatment strategies.

A discussion on the use of diagnostic schedules such as the DSM-IV (1994) and the effects of labeling was included in Chapter Two. To recap, labeling is more frequently described as a negative and isolating experience which is likely to further compromise a person experiencing mental health difficulties (Crocker & Major, 1989). To extend this discussion, it is helpful to cite an example of the stigmatising experiences of people who have been told that they have a mental health difficulty. In her personal account of depression, New Zealand psychologist Gwendoline Smith (1996) writes of the shame and despair she experienced on being told that she was depressed. She believes that such emotions result from myths and misconceptions connected to common understandings of mental health difficulties and ‘psychiatric medicine’ (Smith, 1996, p.31).
Whilst the literature on labeling tends to provide a predominantly negative view of this process, this did not match the participants’ first impressions of being labeled clinically depressed. Here are some of the examples of this experience described by the participants:

**Minny:**

> They told me at the [mental health service] that I had depression. It was a relief to know that something real was wrong with me and that I could get help. It was like a turning point.

**Ella:**

> I went to [the service] and got the evaluation done and they told me that I was depressed and I was almost relieved to know what was wrong, just to know there was something wrong. Like it was actually good for me to have a label after going to all those doctors and having all those tests and being told there was nothing wrong.

**Pam, mother of Lacey:**

> I felt like it was a relief that they can treat this.

**Kim:**

> I was referred to a psychiatrist who told me that I was depressed. It was kind of a surprise and I don’t know if I really believed it, I thought that everybody feels like that and that I could just snap out of it. Like I was happy after a while though, that someone had put a name to it and that it could be medicated.

**Mandy, mother of Kim:**

> It was pretty devastating really although it was also a relief as finally we felt as though something would be done.

**Tess:**

> Well, I had taken the overdose and then I went to [the mental health service] and they told me that I was depressed. It was like a real relief as I finally had
something that meant that people would have to listen to me and that it wasn't just all in my head, it was real. Like I'd thought that I was going really mental. I could put into words what was going on for me. It was like a complete understanding.

The most interesting aspect of these reports is that the first reaction was not reported as a negative experience, rather it was a relief, potentially establishing a position of hope for the future. Furthermore, the notion of self-esteem being reduced on being told that they were depressed (Crocker & Major, 1989) was not evident in the participants' accounts. I interpreted that this was connected with their experience of interacting with a clinician at the mental health service who held an "expert" status. For the young people who felt relieved that they had been offered a diagnosis of depression, their belief in the 'authority' (Fisher, 1990, p.61) of the clinician at that time was more important than their experience of the potential stigmatisation attached to being labeled. This could be constructed as follows: if a young person is attending a "specialist" service and having contact with clinicians who they have been socialised to believe they possess "special" knowledge, the potential exists for the information to be accepted as "the truth". If the information is delivered in a way that invokes hope, then it is likely that there will be a sense of relief, especially where the young person had felt different, but had no framework in which to place the experience.

The belief that the clinician holds specialist knowledge is not only likely to be held by the young person. Frank and Frank (1991) suggest that the more 'indoctrinated' (p.161) the clinician is in relation to their own beliefs about the therapy that they are offering, the greater their ability to 'inspire patients' hope and confidence', (p.161). They contend that the extent of indoctrination is likely to be linked to the clinicians' training programme where they learn to believe that the treatment that they offer will be successful, and that their skills place them in an elitist group of mental health professionals. The more affiliated they become to this group, the greater their altruistic belief will be in the value of
their treatment. The stronger their belief, the greater their ability will be to persuade clients that they will be helped.

If we relate these suggestions to the participants, Minny, Ella, Tess and Kim felt relieved that given the authority of the clinicians, something real had been offered to explain their experiences, and that this information had been offered in a way that they accepted and trusted to be the truth, therefore inspiring hope. They also expressed relief at being told that there were identified treatments to treat their experience.

**Participants’ Thoughts on Therapy**

From my knowledge of youth mental health services I was aware that when young people attend a service and a medical diagnosis has been formulated, if the young person is to continue to attend, options of intervention will generally be discussed. Examples include psychological therapies and medical options such as medication. At this point in the client-to-clinician relationship, the clinician assumes responsibility for the care of the young person. The role will include such tasks as providing the interventions sanctioned by the service, or acting as a broker for the young person, organising aspects of care to be offered by others. It remains the responsibility of the clinician to monitor the young person’s mental health status (recording mood state, suicidality and general functioning from a medical perspective), and to consult and liaise with significant others where this is appropriate and consent has been obtained. Where a psychological therapy has been offered, the model of therapy will be determined by what the clinician has been trained to offer, providing that the model of therapy has been accepted for use by the service. Therapy modalities include Interpersonal Psychotherapy (Klerman et al., 1984), Cognitive Behavioural Therapy (Beck, Rush, Shaw & Emery, 1979), Solution Focused Therapy (Berg, 1994), Family Therapy (Walsh & McGraw, 1996), or Motivational Enhancement Therapy (DiClemente, 1981). Therapy may occur on an individual or group basis.
The current thinking on the delivery of mental health services places an emphasis on the importance of ensuring that a young person is fully informed of all aspects of their contact with services and the interventions that are offered. Information given to a young person would be likely to include what the expected effects of therapy are, what the time required is expected to be, and how to approach the situation if they are dissatisfied with any aspect of their therapy. This information is considered to be essential to a service delivery that is cognisant of the client’s needs (Ministry of Health, 1997). The rationale behind this process is the empowerment of the client.

Where a medical option has been suggested by the mental health service staff and agreed upon by the young person, the clinician will take the responsibility to monitor the effects and to ensure that the young person and their caregivers are fully aware of all aspects of the chosen medication. The clinician may not have personally prescribed the medication as the service employs staff from a variety of disciplines. Responsibility is taken to ensure that regular medication reviews occur. In the interviews I explored the ways in which young people interpreted the chosen treatments and their delivery.

(i) The Psychotherapy Option
For many young people, given the foreign nature of the concepts of mental health difficulties and treatments such as psychotherapy, it is hardly surprising that the idea of needing therapy could be viewed as confusing if not frightening (Belkin, 1988). Kim describes this well. Kim had been in hospital before being referred to the mental health service. Her perspective of therapy during that period follows.

Kim:

It was really hard as I didn’t know what I was meant to say and I didn’t know what was expected. I just thought that I went to the session and blabbered on and I couldn’t see how that could be very constructive. Like I didn’t know what type of therapy it was and it was just talking about things
that had happened during the week. It didn’t seem to be going anywhere. It was like a chit chat session. I’m a person who likes structure and routine and I didn’t feel it had any of that. I was told by the nurses that that was because I was too sick to do anything else at that point, like my brain wasn’t functioning, but I still disagree about that.

Kim identifies some key issues from her perspective of the importance of being informed of the nature of the therapy, why this choice has been made and what is expected to be gained. If we use the medical model as a framework to understand Kim’s comments, we can see that Kim had been given a ‘sick role’ (Turner, 1995, p.5) and a message that she was too sick and vulnerable to understand or make use of therapy (Waldegrave, 1990). When Kim was “allowed” to enter a therapy relationship, she described a sense of moving forward. On reflection, Kim was able to recognise how the medical dominance and her position of relative powerlessness rendered her as impotent to address this situation at that time:

Kim:

_It was the hospital thing, I felt like I was treated like I didn’t have a brain, and I probably believed that too. Things got a lot better when I started in therapy at [the mental health service]. ‘Like I was told what I was supposed to be doing and we set goals every week that I could work on. I felt like I was achieving something, and she [the clinician] made me challenge how I saw things. You have to think about what you are going to do and practice it out in real life._

An analysis of Kim’s description of ‘the hospital thing’ (before her actual therapy began) includes attention to Kim’s feelings of self-worthlessness and the effects of demeaning messages (‘I felt like I didn’t have a brain’) on her self-esteem.
Factors Influencing the Experience of Therapy

Several factors were reported as having influenced the participants’ views of attending the mental health service and the treatment they received. Two important factors described by participants were:

(i) the notion of the participants’ choice with regards to clinician to young person match and the type of therapy offered;
(ii) confidentiality.

These factors will be explored separately:

(i) The Clinician-to-Young Person Match: The Power to Choose

I examined the young people’s perspectives of the client-to-clinician match because I was interested in exploring factors that might influence their perception of the success (or otherwise) of the therapy offered. Frank and Frank (1991) suggest that ‘the success of all methods of psychotherapy depends on the patients’ conviction that the therapist cares about them and is competent to help’ (p.154). In his review, Manthei (1988) suggests that there are a multiplicity of factors present in the client to clinician match that may contribute (or otherwise) to a successful therapy outcome. Manthei supports the notion of client choice in the matching process of clients-to-clinicians, suggesting that it is likely that this process improves the opportunities for successful outcomes.

The clients at the mental health service have a limited choice over which clinician they are matched to, this decision being made by service staff. The participants articulated their views in this area:

Kathryn:

I didn’t get to choose who I saw, but I felt OK about talking to her, so it didn’t matter much to me. I’m not sure what I would have done otherwise.

Tess:

I didn’t feel like I had any choice about going there to start with, so I didn’t care who it was I saw as I didn’t really want to see anyone at first.
Minny:

*I don’t know if you have a choice there [the service]. I’m not sure I wanted to be there at the start, so it wouldn’t have mattered who I saw to start with anyway.*

These comments reflect the participants’ initial indifference as to which clinician they would see. Minny connected this with her limited choice in the process of attending the service.

Some of the participants commented on the factors that they felt were important in their relationship with the clinician once contact had been established. The first comments relate to gender:

**Lachlan:**

*I was cool about seeing a woman as I felt that it would be more comfortable.*

**Joe:**

*I would have wanted to see a man, and I got one, so that was good, so even though they told me that I could talk to them about seeing someone else if I needed to, I don’t feel that I could have done that, like I felt like they were the experts and I didn’t have the right to want to change who I was seeing.*

For Emily, the appearance of the clinician was an important factor:

**Emily:**

*I liked M. [clinician] from the start, she looked crazy enough for me, like her clothes are really cool. Like if they are with it kind of people then they would get on with people better, yeh, turned on. Even though I was told that you could change I don’t know that I could do that, like I was really there getting help, and you can’t ask for too much in those situations. I might make excuses not to go.*

For other participants the important factor was trust:
Suzie:

I liked both of my case managers but it took a while until I could trust them. I don’t know what I would have done otherwise.

Kim:

I really got to trust A. so it wasn’t an issue, although it took a while. She knew about the stuff I liked and I wanted to talk about.

The participants who offered comments in this area all felt that the person to clinician match had been satisfactory, and that this contributed to them continuing their attendance. It is also clear from their comments however, that if an appropriate match had not occurred they would not have felt able to address this, even though some of the participants recalled being told that they were able to do so. As Emily had described, ‘you can’t ask for much in those situations’ and ‘it would be easier not to attend’. When I asked Emily what situations she was referring to she stated:

Emily:

You know, like sometimes I was called a client and sometimes a patient, and when you are a patient you really have to accept what they say because they are the ‘experts’.

I suggest that the participants perceived inability to express their dissatisfaction with their clinician may be explained by examining the difference of power in the client-to-clinician relationship. Emily articulates this well by identifying her status as patient and the clinician’s status as expert. Frank and Frank (1991) describe that the therapists’ perceived competence may have been measured by the young people in terms of qualifications and aura of expertise creating an increasing power difference. In other words, the greater the therapist’s perceived importance, the greater the power imbalance (Frank & Frank, 1991). The participants’ would be unlikely to voice their preference for a change of therapist because of their position in the therapy relationship.
The literature suggests that in order to attempt to redress this power difference, there are several factors that need to be addressed. In addition to the factors identified by the participants such as gender and appearance, others include age; or interpersonal differences such as differing styles of communicating; and cultural factors (Frank & Frank, 1991; Ivey, Ivey & Simek-Morgan, 1993).

(ii) Therapy and the Complexities of Confidentiality

In my experience when a person attends a clinician, if a trusting relationship is to develop, the issue of confidentiality between client and clinician needs to be addressed. Generally the client needs to feel comfortable that the information that is being discussed remains their property and is not shared with others by the clinician except where this has been negotiated between client and clinician (Denkowski & Denkowski, 1982).

The interviews with the participants identified a number of complex issues around the maintenance of a young person’s confidence by a clinician in the therapy relationship. Two of the issues that were explored related to the rights of caregivers, and the ethical requirements of clinicians to maintain a young person’s personal safety.

- Maintaining confidence versus the perceived rights of caregivers

The involvement of caregivers during a young person’s contact with a mental health service requires a consideration of the exchange of information that occurs and how individuals’ privacy is maintained. The principal themes are authority, power and control: the authority of the clinician to involve the caregivers, and the issues of power and control in the parent-to-young person relationship. The caregivers in this study described that living with a young person experiencing depression placed considerable strain on the family, and the caregivers needed to be involved in the young people’s contact with the mental health service in order to feel supported, and to be able to offer support to the young person. The young people presented mixed feelings about their caregivers’ involvement as will be shown. What, and how much information is
offered to caregivers has been a central issue in the delivery of care to young people attending mental health services (Ministry of Health, 1997).

‘The Health Information Privacy Code, 1994’ is an official act designed to protect an individual’s confidentiality (Ministry of Health, 1997). With its introduction the issue of confidentiality has become more complex as the rights of young people over the age of 16 years are defined and interpreted. Mental health services have used their interpretations of this act to develop policies, an example being the right of a young person 16 years or over to be offered a choice on matters such as the sharing of information to caregivers. Caregivers may have clear views regarding their perceived rights to information connected to their responsibilities as parents, and these may be in conflict with the mental health service. The interviews provided an opportunity to explore this area.

The following descriptions from both young people and caregivers relate to caregivers being involved in the young person’s contact at a mental health service and are typical of the perspectives offered.

Dawn, mother of Damien:

He hated me being there [the service], he hated me organising it.

Pam, mother of Lacey:

I wasn’t a part of the treatment because Lacey didn’t want it, but I think they should have recognised that I was the one that cared for her and that there were some things I needed to know so that I could do that safely. All they would say is that we can’t help her if she doesn’t open up. I felt like screaming. It had been 18 months and all she still wanted to do was die.

Emily:

I don’t know, my personal choice would be that I prefer Mum not to be there. I don’t mind if she comes in when we discuss medicine or something, but I prefer that she’s not in
the room, like I would feel strange with her there, just watching or something. OK, it was good that Mum understood a bit about what it was like for me. I was asked if it would be all right if she [clinician] met with Mum there to start off with, and she told me what she might ask Mum and gave me the opportunity to tell her what questions that I would prefer she didn’t ask Mum and that was OK.

Trina, mother of Emily:

I’ve been careful not to interfere with Em’s contact with M. [clinician at the mental health service], but M. has been fantastic about keeping me informed of important things like the tablets. We’ve had a few joint sessions too, although I don’t know if Em. found those that easy.

What is identified from these descriptions is a general cautiousness around the involvement of caregivers by participants, and the quest by caregivers to be offered more. The literature overview outlined that one of the developmental tasks of adolescence is to seek independence from family in preparation for adult relationships (Hill, 1993; Offer & Schonert-Reichl, 1992; Rutter et al., 1976). Therefore, the young people’s perspective that they want to exclude their parents from the therapy process is not surprising. Where caregivers in this study have been excluded from regular and open contact with the clinicians, this appears to have been tolerated when there was a prior discussion between participants and caregivers clarifying what information could be shared. Caregivers then felt that they had been kept informed of aspects of contact for which they felt they had some responsibility for, an example being medication.

- Clinicians breaking confidence where there are safety concerns

It is an ethical requirement of clinicians that they maintain confidentiality unless there are safety concerns for the client or others (New Zealand Association of Counsellors, 1991). One of the features of clinical depression is suicidal ideation (DSM-IV, 1994, p.320). How do young people understand the ethical requirements of clinicians to break confidentiality where there are safety concerns?
concerns given that trust was identified as important for participants in their client-to-clinician relationship? The following comments represent the participants’ views in this area:

Joe:

I’ve been to see a number of counsellors and one of them spoke to my parents about me wanting to take my own life, and didn’t tell me, so I had been meeting with my last counsellor a long time before I felt like I could trust him.

Kathryn:

She told my mother when I told her that I had thought of hanging myself. I was really angry at the time, although I sort of knew that she would tell her. I think that if I was really serious about it again, I wouldn’t tell next time.

Ella:

I didn’t care if I lived or died, and I sort of knew that she probably couldn’t really have stopped me if I tried something anyway, so I told her, she told the people that I was staying with which was really awful, and then I felt like I was a burden to them, so I moved not long afterwards. I felt like she had let me down, she didn’t tell me that she was going to tell those people and I didn’t trust her much after that. I would liked to have known.

These statements highlight the complex issue of safety and confidentiality, and the ethical responsibilities of clinicians which may be perceived by clients as a betrayal of confidence when information is shared with others. For Ella, the clinician has broken confidence to inform the carers of Ella’s self-stated risk of self harm, yet in doing this has alienated Ella from the carers and herself. For Kathryn, informing her mother firmly established Kathryn’s thinking that if she became seriously suicidal in the future, she might not admit to this. Whilst not advocating for clinicians to refrain from sharing a young person’s suicidality, it must also be recognised that breaking confidentiality is not straightforward and needs to be carefully considered. There may be different approaches to breaking
confidence that have a better outcome for the maintenance of a therapeutic alliance. Ella suggests that being kept informed of the clinician’s intended actions may have assisted in this process. The implications for clinicians in their care of young people experiencing depression is explored at the end of this chapter.

Aspects of Therapy Identified as Helpful

The literature suggests that the factors that have been said to increase the likelihood of people describing the therapy they have received as helpful are attributed to both therapist and client. Therapist factors that have been identified include empathy, genuineness and warmth (Frank & Frank, 1991; Truax & Carkhuff, 1967). Client factors include an ability to interact interpersonally and a motivation to do so, an ability to experience emotions such as unhappiness, being prepared to trust others, and a sense of self-responsibility or ‘internal locus of self control’ (Frank & Frank, 1991, p.170).

I asked all of the participants if there were any aspects of the therapy offered at the mental health service that they considered to be helpful. The participants offered the following descriptions:

(i) The Environment

Lachlan:

A cool waiting room is necessary so that you don’t go into the appointment feeling really uncool. Stuff so that you don’t get real bored.

Emily:

Um, the toys in the room, things on the wall to look at, and the walls need to be colourful, I like colourful things. The toys need to be just things to touch though, not games because they make you take your attention off your counsellor when you are meant to be listening. Like I would get quite frustrated because I couldn’t do both properly.
Kathryn:

Yeh, nice colours and good things to fiddle with. Those fuzzy things [pipe-cleaners] are good.

(ii) Clinician Skills

• Listening

Joe:

I've been to quite a few counsellors. I think the ones that have helped the most are the ones that I know really listen to me and then we look at things that I can do to make me feel better. I know that the things that we have looked at like confidence and assertiveness have really helped me.

• Listening and addressing issues in a positive way

Suzie:

It's great to have someone who you can talk to who is not going to fly off the handle. Like T. [clinician] just perks me up somehow. I can tell her anything and she will just help me to look at things positively. The most important thing is that someone is listening.

• Language

There were two issues identified by participants that were connected to the language used by clinicians. The first relates to the clinician's ability to use language that is identified in youth culture as is reported by Emily, and the second is for clinicians to be aware that the language that has been adopted by mental health professionals is likely to be foreign to clients. McConville (1995) suggests that the use of ordinary language assists the client to elucidate 'a deeper meaning and structure of the world' (p.192). If clinicians are unable to use the language of the client, a therapeutic connection may be more difficult to establish. Examples of this were offered by Emily and Suzie:
Emily:

*I think it is important that your counsellor is cool enough to know all of the slang that we use so that they can understand what is being talked about.*

Emily identifies that clinicians should be familiar with the language of the youth culture. For Suzie, it was important that the clinician used language that she could understand:

Suzie:

*One of the things that was good for me was that I could understand what T. [clinician] was talking about. I have been to other places and seen other therapists that I could hardly understand what they were talking about. It was a big waste of time.*

- **Teaching the art of challenging thoughts**

For Joe, a helpful aspect of therapy was learning how to challenge his negative thinking:

Joe:

*I used to think that I was really dumb and that no-one liked me at all. My therapist taught me that this was really negative, and that when I had these thoughts I should try and stop and think to myself that those thoughts are maybe not right and that the people maybe didn’t think that way about me. That helped me.*

- **Teaching new behaviours: distraction**

For Tess, an important part of the therapy was learning a technique of diverting her thinking when her thoughts were predominantly negative, and receiving positive and reinforcing feedback from the clinician:

Tess:

*They teach you to practice things like distracting yourself. Like I’ve got this sort of list in my mind and it is really hard to motivate myself to do it but it really helps, and especially*
when I can go see V. [clinician] and let her know that I’ve been doing the things that we talk about.

- **Ventilation: Of thoughts and feelings**

  **Kathryn:**

  Like I used to think that all I had to do was get it all out. To talk about it all. But now I don’t know if that’s the whole answer. Like maybe talking is only the start. I know that there’s more to do yet.

  In this description, Kathryn identifies that for her, being able to talk about her experience may be only the beginning of the therapy process. Other participants also identified this phenomenon:

  **Tess:**

  Like, just talking about your stuff helps, but it isn’t enough, you have to do something about it.

  **Lachlan:**

  You need to talk about your shit, but you need to do some stuff too if you want to do anything about it.

  In their discussion the participants have articulated a need for therapy to promote change. In their review of definitions of therapy, Shertzer & Stone (1980) suggest that promoting change is a central tenet common to all therapies. It follows that if this is not achieved, the therapy is either ineffective or incomplete.

- **Manageable goal setting**

  An important aspect of a therapy process that promotes change is goal-setting. The participants identified the importance of goal-setting as necessary to successful therapy:

  **Tess:**

  *We did this goal setting thing that each time I would see V. we would go through the week and look at what I had done, and then plan the next week so that I had some goals. That really helped. I could only manage to do things on a week to week sort of basis. Sometimes it got down to hour to*
hour. Like my first goal was to get out of bed. That sounds really silly now!

Emily:

Having someone to talk to every week, and being able to talk with someone that's not in your family, and I made plans for the days, like before that I just wouldn't do anything all day.

Goal-setting has been identified as essential to the therapy process, although how and when this should best occur differs markedly amongst a variety of therapy models (Belkin, 1988). For the participants, goal-setting was an important part of their therapy. They were able to identify a “start-small” philosophy where goals such as getting out of bed were a part of the therapy process, and supported a move towards recovery.

- **Problem solving**

The participants also identified that using analogies was helpful to clarify experiences in the problem-solving process. Suzie used the analogy of a spiral to explain her situation and found this helpful:

Suzie:

\[
\text{and I worked out this spiral theory that really works for me. I can draw it now, it fits in with my visual sort of way of getting things. I draw the spiral then write in the things that are making me spin downward. It helps me to understand it, so that I can figure out ways of changing the direction of the spiral. T. lent me a book from their library and that's great too.}
\]

Lacey's mother was also able to identify the process of problem solving as helpful for Lacey:

Pam, mother of Lacey:

\[
\text{There were some things that T. taught her like problem solving stuff. Getting in touch with friends or family if she needed some help working stuff out. That kind of stuff.}
\]

Minny’s comments also describe the importance of problem solving:
Minny:

*Having someone to talk to who isn’t in your family is great. Like being able to talk things through helps you to look at them differently and helps you to make a plan about doing things differently.*

What is interesting about what is described as being helpful during therapy is the simplicity of the therapeutic techniques. These techniques are common to all of the therapy modalities offered at the mental health service. The range of therapies that are offered could be viewed as confusing and complicated, yet it is the simple therapeutic tools common to all therapies such as listening and using identifiable language (Ivey, Ivey, & Simek-Morgan, 1993), that are identified as being helpful.

**Unwillingness To Attend**

For some young people the option of therapy is not taken. As was earlier described, the ability of a young person to connect with the service and its staff will determine what interventions will be accepted. If a connection between clinician and client has not occurred then the therapist is unlikely to persuade the young person that from their perspective, what is being offered is necessary. The process of connecting with a clinician is often referred to as ‘engagement’ (Masson & O’Byrne, 1984, p.28). The following description from Damien’s mother highlights this phenomenon.

**Dawn, mother of Damien:**

*I think they really tried to help him, but he didn’t really want a bar of it. I think what would help him would be for him to be living in an environment where there was structure and discipline, with people he could open up to and respect. At the end of the day he has to want to make some changes for himself and I don’t think he has the motivation to do that. He’s a lovely kid but he’s digging a big hole for himself.*
From Damien’s mother’s perspective, if a young person is determined not to be engaged into therapy, then it is unlikely that this will occur. She believed that engaging in some sort of therapy was so important for Damien, that because of his reluctance, this would need to occur in a residential setting where he had less choice. Whilst J.’s understanding of Damien’s reluctance to attend was due to a lowered motivation, it could be argued that resisting the persuasion of clinicians would require considerable motivation when the power of their influence is considered.

Frank and Frank (1991) suggest that the power of the clinician’s belief that what they are offering is valuable is sufficient to convince them that a failure of the person to engage in therapy will result from factors which are client centred rather than attributable to the therapy. An example that is offered is ‘negative transference’ (Frank & Frank, 1991, p.161). Negative transference implies that the feelings that the client holds for the therapist interfere with their ability to utilise the therapy that is offered. The therapists’ beliefs about the therapeutic value of the therapy are therefore protected. To me, this explains how the clinicians are able to maintain their beliefs about the value of their therapy when confronted with clients who are reluctant to attend, or do not find the therapy useful.

**A Final Comment on the Therapy Option**

Finally in the area of participants and therapy, Kim makes a comment about the value of therapy from her perspective:

**Kim:**

*The thing about therapy is that it’s much more of a long term change compared to medication. Once you’ve stopped the medication the same problem might come back. It’s also about sorting out problems now rather than later. It has helped me to see that the way that I look at things is not necessarily right and that everyone looks at things differently.*
(ii) The Medication Option

A Personal Impression

Throughout my studentship and career, I have listened to many debates on people’s views about medication being considered as a valid intervention in the treatment of young people with mental health difficulties. At the centre of this debate is the question: should a medical intervention such as an antidepressant medication be used in the treatment of young people experiencing depression? Whilst mainstream mental health services in New Zealand would support the use of antidepressant medication as a valid option, there remains a skepticism amongst the general public that is frequently reported in the local media. Whilst the medical practitioners support the need for medicine as a treatment option, it cannot be denied that previously, medications have arrived and been upheld as new and successful treatment options, and have just as quickly lost favour. Some medications have endured the breadth of my career, yet from my observation, remain less than perfect in their efficacy and side effect profiles.

Personally, I respect the use of medication when young people present with a level of depression that has left them “frozen in their tracks”. When the young person, their friends and family, and staff at a mental health service become aware that communication appears impossible due to what is medically recognised as impaired thought processes, then medication is an option. Introducing medication and then watching an improvement over weeks is very convincing. This is especially so when the experience of depression has been present for months to years.

The Process

When a young person has been evaluated by a mental health service as being significantly depressed, it is likely that in addition to the psychological therapies, they will be offered medication as an intervention option. As discussed in Chapter One, the most common medicine offered to a young person will be one of the Serotonin Selective Reuptake Inhibitors (SSRI’S.) (Kucher, 1997). Two examples of SSRI’S are fluoxetine (prozac) and paroxetine (aropax). These
newer antidepressants are chosen because the literature suggests that there has been an improvement in their side effect profiles when compared with the older tri-cyclic antidepressants such as nortriptyline and amitriptyline. Additionally the newer variety is considered to be less toxic in overdose, and whilst few trials have been completed to date, there is a significant amount of information that suggests that these medications are suitable and successful in the treatment of depression during adolescence (Kucher, 1997). When a young person and their family are encouraged to consider medication as an option, their decision will be influenced by their beliefs and attitudes. Such beliefs may include that antidepressant medication is addictive, mind altering, will encourage violent or suicidal behaviour, or is only for mad people. If the medical person believes that the medication will be helpful and imparts what they believe to be truthful information, it is likely that they will be persuasive. In doing so it is probable that they will use their one-up position of the medical specialist. Again in this thesis, I was interested in understanding how young people and their caregivers make sense of this.

**Understanding Information about Medication**

Throughout this research I have heard of the difficulties young people experience in communicating with other people when depressed. Comments such as this example from Ella were typical of this experience.

Ella:

*I couldn’t think, just couldn’t concentrate, my mind felt like it was full of cement.*

My interpretation of this is that the young person has difficulty receiving and processing information, and this may be manifested as a concentration problem, as Ella described. The effects of these difficulties in communicating with other people are a social withdrawal and a sense of detachment from others, as Kim described in Chapter Four: *‘I was on the outside of the group who I had called my friends, unable to join in anything as I felt like I just wasn’t a part of them’.*

If this experience occurs during the communication with a clinician, it is possible that the young person may not understand the information given to them.
on important subjects such as the wanted and unwanted effects of medication. Here are some examples where this may have occurred.

**Kathryn:**

> They probably did tell me [about the medication], but I didn’t get it.

**Ella:**

> I got home and I couldn’t remember much of what they’d said about it so I didn’t do anything until the next time that I saw them.

**Lacey:**

> They kept on telling me more and more, and I couldn’t tell them I didn’t understand, so I just kept on nodding as if I did understand.

These comments highlight the hazards for young people of being given instructions which they find difficult to assimilate into understanding. It is likely that a number of factors will have contributed to the participants’ “not hearing” the information, examples being fear, distress, or disbelief. There are implications for clinical practice which are discussed at the end of this chapter.

**To Take, or Not to Take the Medication**

The decision to accept medication does not always mean that the young person will be convinced that this is a good option and will be followed through. Damien’s mother offers her perspective:

**Dawn, mother of Damien:**

> He would never have remembered to take it if I hadn’t given it to him, and because he was not staying here that often I don’t think he had it often at all. I think he saw it as a sign that people thought that he was crazy or something, so he wasn’t committed to taking it anyway, although he wouldn’t have told them [clinicians] that.

Emily offers a similar perspective:
Emily:

When they told me that I needed to have medication I thought that that was it, I was so crazy that they thought I needed to have medication, why couldn’t I just snap out of it? I didn’t tell her [clinician] that I wouldn’t take them as I didn’t know what to say.

Damien and Emily did not believe that they needed medication, seeing this as confirmation of their madness. This relates to their concerns about being stigmatised by others for taking medication. They therefore chose to not take the tablets and not inform the clinician of this decision. My understanding of this was the power difference in the relationship between young person and clinician, that it would be difficult to explain their actions to the specialists.

Others’ Understanding

Following on from Damien’s belief that he would be viewed as mad by others, several other participants offered their views about telling others that they had been prescribed medication.

Tess:

When they told me that they might prescribe prozac, I was a bit freaked at first, I didn’t want chemicals and stuff. A couple of my friends got a bit stroppy about it. They would say stuff like ‘Oh she’s on pills, she’ll take them all’.

Kathryn:

I wouldn’t have told my friends. Like they don’t know anything about depression, they think that tablets are for loonies.

Suzie:

She [flatmate] couldn’t handle the fact that I had left my medication on the bench. It was like some kind of reminder or something that I was a psycho.
Minny:

\[ I \text{ didn't tell anyone about the tablets, they thought that I was psycho enough. } \]

What can be taken from the participants' comments is that the choice not to tell others was based on a belief that they would be viewed differently, and that disclosure would be neither safe nor useful. Once again we are offered an understanding of the discrimination that is attached to issues of mental health, in this instance, medication-taking. What is noted here is that the beliefs expressed by the participants about how they would be perceived by others reflects their own stigmatising thoughts on mental health difficulties.

Furthermore, by concealing the information that they are taking tablets, they are unwittingly but understandably perpetuating their own and others' beliefs about mental health difficulties. For example, if their medication-taking is discovered by others, and these people become aware that the young person has attempted to conceal their difficulty or their treatment, it may be perceived that they are ashamed of their situation, further supporting others' discriminating beliefs.

**Great Expectations**

Several of the participants described that when they were informed by clinicians of the advantages and disadvantages of accepting medication as an option, they were also told that the aim was for a considerable improvement in mood. The following descriptions highlight this:

**Kathryn:**

\[ I \text{ was told that if the medication worked I could expect a 100 percent improvement in my mood. } \]

\[ I \text{ kept waiting for that. Like I think it did help but it didn't help that much. } \]

**Kim:**

\[ I \text{ took a long time to get the medication right, and that was so frustrating. Each time they [clinicians] would explain about it I would think, I'm going to be right now, but my } \]
mood would stay low. Like I was told that they were aiming for 110 percent improvement, and it just wasn't happening.

Mandy, mother of Kim:

Well I think I believed at first that she would start the medication and would start to get better, but it hasn't been like that. She has had lots of trials of different tablets and different combinations and it has taken a long time to get things nearly right. They are still saying that she's only about 70 percent better and they are aiming for more. I find this all pretty frustrating. Like I worry that they have told us that she will need to be on these tablets for at least 18 months. I worry that she will have this thing forever and what if she stops and gets worse? How will they know when it's a good time to stop? I try and be positive to her when I don't feel that positive myself.

Once again these comments highlight the difficulties when people who are viewed as holders of special knowledge offer what may be well intentioned, supportive comments that are precious to the recipients, but which may lead to disillusionment or despair when the claims are not met.

**Wanted and Unwanted Effects**

Despite claims that there has been an improvement in the side effect profiles of the newer SSRI antidepressants when compared with the older medications (Kucher, 1997) there are some side effects that are relatively common such as nausea, heartburn, headaches and less frequently, rashes. Generally if these do occur, they will have settled within the first week. As the medication is reported in the medical literature to take between two weeks and a month to have any demonstrable effect on mood, it may be that side effects are all that the young person will notice when commencing the medication (Kucher, 1997). In my clinician status, I have heard from young people that this discourages ongoing self-administration. Some of the participants reported their need for quick responses to interventions offered, and having to wait for what may seem like an
eternity to recognise any wanted effects made the medication option seem even less attractive. Here are some of the comments from young people and caregivers on this subject.

Lacey:

They told me it would take around a month or so before I would notice much, and that seemed like forever. When I finally agreed that I was depressed, I didn’t want to be waiting around forever.

Joe:

Dr. A. said it would take a few weeks to work, but I needed to be better straight away.

Other comments were concerned with the frustration experienced by the participants when they did not notice an improvement in their mood in the expected time. They may then be told by clinicians that the medication needed adjusting:

Trina, mother of Emily:

I had no trouble with the idea of tablets as I had been on antidepressants and they had really helped me. I do sense Em’s frustration with them though as it’s taking a long time to get them right, ‘fine tuning,’ I remember the doctor calling it.

The issue of experiencing unwanted effects from the tablets was also discussed, although was not present for all participants.

Trina, mother of Emily:

She has had some side effects like weight gain from her current tablets [Lithium carbonate, a mood stabilising medication], and that is really hard on a young woman.

Emily:

I’ve had some problems with the Lithium, like nausea and that type of thing, but that’s sorted out now. I’ve got so fat since I’ve been taking it though. It’s awful. And there are
other things to remember. Like you can’t drink any alcohol or you feel real sick.

Ella:

I felt really sick for a few days.

Lacey:

I had lots of trouble with them at first, feeling sick and headaches, but I got used to them, although they had to be changed a lot before they could find one that worked.

Joe:

They were fine.

These comments highlight the range of unpleasant side effects that some young people experience. None of the participants had experienced initial side effects that persisted for more than a few days. No one decided to stop the tablets as a result of the side effects. My interpretation of this was that they had accepted the advice from the specialist that they were experiencing an illness and that medication would help them to become well again.

Some side effects were tolerated better than others. For example, nausea and headaches were less likely to influence a young person’s decision to stop taking the medication than weight gain. Given the links between weight gain, body image and a sense of self (see Rice, 1990), I did not find this surprising.

**Feeling Changed**

The desired effect of antidepressant medication is to improve mood. The participants were told that improvement is expected to occur gradually over a period of weeks. Some of the participants described that the medication made them feel different or changed. All of the participants had been experiencing depression for months to years, and many described that they had forgotten what feeling anything but depressed was like. Here are some examples:

Lacey:

I was on medication and I was getting better quite quickly,

I’d tried lots of medications that didn’t work, and then all of
a sudden I started to feel good. And then you are stuck with a personality that you don't really know. Like I'd gotten used to being a certain way, and then I began to feel different again. It's quite scary, and I didn't feel comfortable with it, so I stopped taking the medication, because I didn't want to get better, and have to deal with feeling different again.

Here are some similar perspectives:

Kim:

I felt like it changed me and for a while I didn’t know who I was anymore. I had been down for so long that I didn’t know anything else.

Lachlan:

Things have got much better since I started the medication about two months ago, but it’s like I don’t know if this is the real me or that was the real me. Like it’s been so long since I have felt OK that I’ve forgotten what it was like. It’s kind of weird.

Suzie:

I felt like I had stopped taking on everyone else’s personality and started to get one of my own. It did feel weird.

Lacey (speaking about her partner):

So when he got on medication he couldn’t handle it. He changed and he couldn’t handle it, so he stopped the tablets and started gambling again.

I interpreted the participants’ difficulty in adjusting to a change in their experience of depression as being associated with the impact of depression on their changed sense of self (see Chapters Three and Four). If depression alters how a young person perceives themselves, and they remain depressed for several months, over time it is likely that they will accommodate to their new experience
of self. When this is altered through the introduction of a mood-improving medicine, they may feel uncomfortable with the change.

A further explanation relates to the effects of the experience of being accepted into a deviant group where they experience a sense of belonging (see Becker [1963] in Chapter Two).

I believe that Becker’s comments on the effects of being labeled as deviant have relevance to my thesis in that the participants described a length of time where they struggled with an altered sense of self that resulted from their depression. They then experienced relief at being labeled as depressed as they had been offered an explanation for their altered sense of self, and this label afforded them entry to a new group. Over time their identity developed alongside the identity of the group. They then struggled with another change that occurred as a result of the treatment, where they lost the familiarity of the identity that they had developed, and their associations to the group (depressed young people) became tenuous.

Yet another explanation is the dynamics of the young person’s relationship with the clinician. As a young person improves in their mood and the clinician becomes aware of this, the expectations of the young person may change and a move towards a return to previous activities may be encouraged. This could include decreasing contact with the clinician. The young person may perceive this as a rejection by the clinician. Up until this point, their understanding from their contact with the clinician has been that they are ill and, therefore, they may have taken the ‘sick role’ (Turner, 1995, p.5). If their identity has developed as a sick person as has been earlier suggested, the young person may feel uncomfortable with an improvement in mood and the associated new expectations from others.
For the young people who found it difficult to adapt to their changed selves and have attributed these changes to medication, their decision was to stop the medication, as was identified in Lacey’s description.

**Feeling Better**

Whilst all of the participants went through periods where they distrusted or felt disillusioned by the medication and did not take it as prescribed, all but one experienced an improvement in mood which they attributed to antidepressant medication.

To complete this area, the participants’ comments on their perception on the worth of medication as a part of their recovery is offered:

**Tess:**

> And it took a few weeks to start to get out of the big black hole. Like there’s the medication and then there’s the counselling. Like you don’t really know what’s helping the most but I think that it all helps together.

**Lacey:**

> It gives you the strength to pick up and get on with doing things rather than dwelling on things all the time.

**Joe:**

> I’ve been on a number of different tablets, and I think they help me, but I still get depressed sometimes, but maybe not as depressed as I used to.

**Ella:**

> If I didn’t have it I wouldn’t be here.

**Issues for Ongoing Contact**

**(i) Over-estimating Improvement**

When young people begin to recover from depression, there is naturally a considerable relief that is experienced by those in contact with them, and this includes clinicians. A potential danger in feeling relieved by the signs of
recovery is that the ongoing difficulties and distress experienced by the young person may be minimised. This is described by Suzie.

Suzie:

I've progressed so much since I came to [the service] but it worries me that I've come so far, yet I've still got a long way to go and people don't realise just what a struggle it is every day.

Suzie articulates her concern that if she is not perceived as depressed, then the help that she has been receiving may stop. This may be related to earlier comments that describe the difficulties the young people experience in having to accommodate to their changing identity that may result from the treatment process. If the young person is uncomfortable with an improvement in their mood because of the changing expectations of others, it may follow that they will be reluctant to accept self-responsibility that would indicate progress.

(ii) Acting

As was described in the Chapters Four and Five, throughout the interviews with participants there were many examples of the use of acting by the young people. When used during their contact with clinicians, there appeared to be two main reasons; to avoid contact with clinicians or to please them:

• **To avoid contact**

It was clear that for one of the participants, acting was used to avoid entering any contact with the service, and was related to his beliefs on the stigma attached to attending mental health services:

**Damien:**

I didn't want to talk to them, I just wanted them to piss off.
so I told them that I was fine. I didn't want a bar of that nut house and all those psychos.

• **To please the clinician**

Some of the participants articulated that they would choose to pretend that they were progressing in order to please the clinicians. Here are examples of this:
Minny:

She had been so good to me, and she[clinician] just knew so much, a real expert, I felt like I couldn’t disappoint her sometimes, and I didn’t always tell her how I really was.

Ella:

Sometimes I felt like I needed to say that I was OK so that I didn’t take up too much of her[clinician] time. She had so much to do, and I felt like I wasn’t important enough to take up so much time.

Kim:

I knew that she must be right because she was the doctor, so I would say that I was getting better, even if I wasn’t sure that I was.

My understanding of these comments is that they relate to both the feelings of self-worthlessness experienced when depressed, and the power difference in the client-to-clinician relationship.

If a young person is experiencing low self-worth, it follows that this will increase the power difference in their relationship with the clinician. This is explained in the following discussion:

In his description of the sick role, Parsons (1951) identified three techniques through which the clinician gains the authority that influences the power imbalance in the clinician to patient relationship: ‘professional prestige, situational authority, and situational dependency of the patient’ (Parsons, 1951, cited in Cockerham, 1978, p.94). Applying these ideas, if the young person is ‘situationally dependent’ on the clinician, it follows that they are likely to want to please them. It would then be difficult to admit to their feelings of distress should these occur, especially if they are experiencing low self-worth as a result of depression.
(iii) Caregivers' Perspectives on Continuing Contact

Of the eleven participants, six were still living with their parents at the time of the interviews. The other five were living in independent situations, although all had been living with parent(s) at some stage of their experience of depression. The following descriptions from caregivers articulate their experience of being involved in the participants’ contact and treatment at a mental health service.

• **Unmet expectations**

The following comment from Kim’s mother relates to her experience of watching her daughter get worse after contact had commenced. Kim was in hospital at this time.

**Mandy: mother of Kim:**

> She actually went further down for weeks after she had first been diagnosed, and I remember being at a meeting when one of the staff said to me that she thought I might be feeling upset because at first I had believed that we could turn this thing around. I lost it then, all I could focus on was that they hadn’t got it right.

This description is important in that it highlights the difficulties that may occur when after a period of contact, the expectation that there will be improvement is not realised. Kim’s mother’s comments suggest that her sense of hope has diminished, and that the experts have failed.

Frank and Frank (1991) suggest that a sense of hope is potentially the most important factor that will build morale for the client, keeping them engaged in the therapy process. Hope is likely to be stimulated through a trust in the clinician’s status and their ability to use treatments that will facilitate wellness. I suggest that Kim’s mother’s comments indicate that hope is as important to caregivers as it is to clients. When expectations are not met, the sense of hope is threatened which may result in disillusionment and anger.

• **Walking on egg shells**

I have addressed in Chapter Three the issue of caregivers not feeling comfortable with setting boundaries for fear that they will push their young person “over the
edge”. This is a subject that (where possible) could be usefully addressed by the caregiver with the clinician. Emily’s mother’s comments are typical of the views expressed by other caregivers in this research.

**Trina, mother of Emily:**

I’ve talked to M. [clinician] about this a lot, and it’s something that I’ve needed a lot of support and guidance with. I worry that even though we have to take things at her pace, that we need to know how much we can expect from her too. I constantly worry about pushing her over the edge, and this has caused a lot of tension between L. [partner], and me.

This description highlights the anxiety that caregivers experience when a young person in their care is depressed. Their ability to parent has been challenged by their belief that by placing boundaries on behaviour, the young person may become more depressed, or that their safety will be compromised by an increase in suicidality. Further to my discussion in Chapter Three, I suggest that this changed dynamic in the relationship between caregiver and young person may contribute to an interruption in the process of individuation. This occurs because the shared understandings about expectations of caregivers by young people and vice-versa are challenged.

Another barrier to the clinician being able to provide support to the caregiver that has been emphasised, is the young person’s need for confidentiality. Unless an understanding has been reached between clinician and young person about the exchange of information between clinician and caregiver, the young person is unlikely to feel confident about sharing their experiences, and the therapeutic alliance is then threatened.

- **Whose responsibility?**

The issue of caregivers taking responsibility for aspects of a young person’s therapy is described by Tess’s mother.

**Hella, mother of Tess:**

Since she’s been going to [the service] I’ve gradually noticed that she’s getting better and better. It still irks me
though that I take a lot of responsibility for her appointments to make sure that she remembers when they are and that she gets there and I can't work out if I'm making allowances for her because she's depressed.

This highlights the developmental issue for parents of the handing over of personal responsibility to young people, and how depression has the potential to interfere with this process.

• Effects on Siblings

The importance of remembering that a young person's depression will have affected the whole family, including siblings, was discussed by several of the caregivers. A challenge to clinicians to recognise the needs of siblings was offered by Tess's mother.

Hella, mother of Tess:

I think that there needs to be a service that offers something for the brothers and sisters of someone who has something like depression in the family. Like it's affected them greatly but I don't know if that's really been recognised. They just did not know which way to turn.

Kim's mother also offered her perspective in this area:

Mandy, mother of Kim:

Like even if they don't talk about it openly, I can see that it's affected both of her sisters in different ways, and I think they needed to be more a part of Kim's contact with the service than they have been.

Both of the comments highlight their concerns that when contact is offered to a young person with depression, the needs of other family members should be attended to as well.

Issues Of Leaving the Service

If it is viewed by the service staff as necessary, young people can attend until 18 years of age, or older in some circumstances. As has been described in this research, recovery from depression is an unpredictable, often slow process. If a
young person attends a mental health service weekly or fortnightly over a period of months as commonly occurs, a significant relationship is likely to have developed between the young person and the clinician. When the time approaches for a young person to finish their contact with the service, the issue of completing their contact with the clinician arises. If the young person is approaching their 18th. birthday, they may have questions such as 'What if I need to come back?'. If the clinician leaves the service after having entered into the therapy relationship, how is this interpreted by the young person? My interest in exploring this area stems from an outcome of the research completed by the Canterbury Suicide Project (as reported by Beautrais, 1998). The times of transition created by artificial barriers such as increasing in age are reported to be vulnerable periods when young people with mental health difficulties are more likely to attempt or complete suicide. The following descriptions articulate the participants' views in this area:

Emily:

It's gonna have to end sometime. I mean, I don't know. I suppose it will just draw to a conclusion when the time comes. Like my sessions with M. are getting farther apart, like every two or three weeks, and I suppose that's what happens. The times between appointments gets bigger and bigger.

Kim:

I see myself getting better and I wonder what it means when I'm good enough not to come here anymore. Like do they stop seeing me altogether and I can't come back, and what if I get depressed again? You get really used to meeting with one person, so if you have to get to know someone else all over again, that would be really hard.

Lacey:

I'm 19 now, so I won't be able to come back here if I get depressed again. I haven't spoken about that with T. Like I sort of avoid talking about it.
The participants’ articulated their concerns at the prospects of both leaving the service, and requiring support for their mental health in the future. None of the participants appeared to be clear about when they would complete their contact, and what would happen if they were to become depressed again. I suggest that this has created a sense of uncertainty and anxiety for the future. If the young person has been involved with the service for some time and has developed an expectation that they need to attend, there may be considerable anxiety at the prospect of moving on. Needing to attend is a position that is likely to have been established throughout the period of contact with a mental health service where a young person has received many messages about having a mental disorder, potentially marginalising them from their peers and encouraging a developing reliance on the medical experts to be helped. Once this expectation has been established, leaving the service is potentially a traumatic time if the arrangements for ongoing contact (if required) do not happen, or if the young person experiences further low mood, and feels unsupported. The implications of this for clinicians can be found at the end of this chapter.

5.3: Summary of Chapter Five

Attending A Mental Health Service

• *The young people’s perceptions*

  The young people felt frightened before they attended the mental health service and they believed that they would be perceived by others as ‘mad’. These concerns were exacerbated because the service was positioned on the grounds of a psychiatric hospital. The principal theme underpinning this phenomenon is the stigma attached to attending a mental health service.

• *Clinician-to-client match*

  The match of clinician-to-client was very important to the young people and they stated their preference to be offered a person of the same gender, race or other criteria specific to their needs. The participants acknowledged that where they perceived the match to be unsatisfactory, despite being told by
their clinician that this could be addressed, they felt that they would not have been able to do so.

**Young Person-to-Clinician Contact**

- **First contacts**
  Young people experiencing depression reported feeling detached and withdrawn when relating to others. First contacts at mental health services tend to be of approximately two hours duration and consequently require considerable concentration and focus. For many young people the nature of depression, in addition to other factors such as fear or anger, prevents this. They are likely to appear to be detached and indifferent, answering interview questions robotically. The majority of the participants in this research had little recollection of the initial interview process. If these presentations are typical, it is possible that young people will be misrepresented in the assessment report that usually follows the first interview.

Participants also felt that if they had contact with more than one service in a short space of time, it was likely that they would be asked to repeat questions that they had recently answered, and they found this frustrating.

- **Finding out**
  For most of the participants, being told that they were medically depressed was described as a relief. All had been experiencing depression for months to years before they had been told, and therefore were reassured that something real was available to explain their situation. A part of their relief came from being told that they could be helped, inspiring hope. For some of the participants, their journey to recovery included periods of disillusionment when their expectations were not met.

- **Confidentiality**
  Maintaining confidentiality is a complex issue. The rights of caregivers and other support people to information must be balanced with the needs of the young person for privacy. Safety issues are also pertinent. A young person
may disclose their suicidality to a clinician. The clinician will be bound by their professional ethics to share this information in an attempt to promote the young person’s safety from intentional self-injury. The young people in this study found this compromising.

- *Therapy process*
  Some of the young people were not sure that the therapy process had been adequately explained to them and they felt unclear about the nature and goals of their contact.

- *Therapy techniques*
  Despite the range of therapies used at the mental health service, the participants identified that the most helpful aspects of therapy were what therapists consider to be the basic techniques of counselling. These included being listened to, the therapist using language that they could understand, allowing the young people to talk through their feelings (to ventilate), problem solving and goal development. Other helpful techniques were described as teaching methods of distraction and being taught to challenge their thinking.

- *Over-estimating improvement*
  As young people recovered, they described their concern that people who they felt were their supports, including clinicians, over-estimated their recovery. This was perceived as no longer being cared for, and created expectations that the young people felt they could not meet. Some felt afraid to disappoint their clinician, their caregivers or themselves by admitting to their continued experience of low mood, and acted as if they were fine. Caregivers also described their experiences of placing a significant importance on the information offered by clinicians, and feeling disappointed and disillusioned when their expectations were not met.

Connected with the young person feeling that others were over-estimating their recovery, caregivers often felt that they did not know what to expect from their young person and had the sense of walking on eggshells.
• *Non-engagement* The initial period of the therapy process involves the clinician ‘connecting’ with the young person and persuading them that they can be helped. This process has been referred to as engaging with that person. The young people described that if this did not occur, they would be unlikely to agree that continued contact was necessary, as it was viewed from the clinician’s perspective.

• *Medication*

For several of the young people, their ability to hear the information that was offered regarding medication was compromised, this being related to such variables as fatigue, poor concentration, anxiety, fear, or anger. Regardless of the level of agreement that was reached with the young person, there could be no guarantee for the clinician that they would commence or continue with medication. Such decisions often occurred without discussion with caregivers or the clinician.

The issue of telling others that they had been prescribed medication was also discussed. Young people chose not to tell people such as friends that they were on medication for fear of being viewed as mad, this relating to the stigma attached to the taking of psychiatric medication.

Young people and caregivers articulated their disillusionment when the medication that had been accepted did not work in the way that they had heard described by specialist staff. I suggest that this relates to the hope that had been established based on young people’s and caregivers’ beliefs about experts now being involved who held the knowledge to address the young people’s difficulties.

• *Adapting to mood improvement*

For the young people who had been experiencing depression for months to years, the experience of recovery was difficult. When a young person has been depressed for several months to years, they make adaptations to their lives to accommodate being depressed. People around them also make adaptations so that they can cope with the young person’s depression. When
an improvement in mood occurred, this often felt so different that this experience was not tolerated and the medication stopped. When the improvement occurred over a longer period of time, the young people were able to adapt to their changing mood, and the differences were then tolerated. I believe that the sense of discomfort associated with recovery is associated with the young person's view of self and identity.

- **Leaving the service**
  The young people described their experiences of feeling confused and ill informed of their futures with the mental health service. When would they be required to leave, and what would happen to them if they should become depressed again? They indicated that they would have felt better prepared for this inevitability if it had been openly discussed.

**Messages for Health Professionals; Intervention Strategies**

**Addressing the Stigma**

- Clinicians need to create opportunities for young people to minimise their distress at being referred to a mental health service. Examples include being offered services within their own environment, or where this is not possible, offering practices that are cognisant of the young person's fears.
- Clinicians are required to be leaders in challenging the beliefs that society holds about mental health difficulties.

**Clinicians supporting young people and caregivers**

- **Creating a facilitative physical environment**
  In order for young people to feel more comfortable in the physical environments of mental health services, the construction or renovation of services must occur in a planned manner where the needs of young people are considered. Where possible, services should be located in community settings instead of mental health institutions such as psychiatric hospitals. Inside services, offices should be equipped with articles that appeal to the tactile senses, yet are not cognitively demanding. Colours should be bright
and cheerful, furniture and furnishings comfortable. An attempt will then have been made to minimise the stress for young people attending a service by addressing their need for comfortable surroundings that are suitable for their developmental stage, thereby promoting an environment where engagement into the therapy process is enhanced.

- **Encouraging a satisfactory clinician-to-client match**
  Services need to consider how they can empower young people to state their preferences before a client-to-clinician match occurs, to address specific needs of clients during a matching process, and how they can support young people and caregivers to address concerns of an unsatisfactory match.

- **Facilitating first contacts**
  To avoid young people needing to answer questions related to their personal history several times within a short time-frame, with the young person's knowledge and consent there needs to be the provision of a co-ordinated across-service response where information that has previously been collected and is unlikely to have changed, is not requested again.

- **The responsibility of clinicians to inform about depression**
  If a diagnosis is offered in a context that can be understood by the young person and their caregiver it will have more meaning and enhance a position of hope. For this to occur, language must be used that can be understood. To provide a context for understanding the diagnosis, where possible, the clinician may consider organising contact with a young person who has experienced and is recovering from depression.

Clinicians need to be aware that the relief that is experienced when a young person is told that they are depressed is based on the hope that contact with a clinician inspires, and that the clinician has a responsibility to inform the young person and caregivers that the path to recovery is frequently long and complex, in spite of the specialist contact. If clear and honest information is either not given or not heard, the opportunity for disillusionment is significant.
• **Advice about telling peers**
As some of the peers of young people experiencing depression may not be able to offer a level of understanding or support that is helpful, young people experiencing depression need to be supported by clinicians in the decision making process of which peers it would be useful to share this information with and for what reasons.

• **Addressing confidentiality**
The tension between maintaining a young person’s confidence and attempting to promote an environment that reduces the potential for self harm, or harm to others, is best addressed where there is clear communication between young people, their caregivers and clinicians.

• **Clarifying the therapy process**
When a young person is offered therapy as an intervention for depression, there needs to be a complete explanation. This explanation should include the advantages and disadvantages of the chosen therapy, the goals and the therapy process, the expected effects and possible unwanted effects, the time involved, the options the young person would have available during the course of therapy, and when therapy ends. This should be delivered in the young person’s language.

• **Therapy techniques: what young people perceive as helpful**
As this research has shown that the therapists’ attributes and attention to basic therapy techniques were more important to the young people than the model of therapy, clinicians need to focus on their basic therapeutic skills. These include listening, probing and reflecting, having clear goals and a clear process that has been communicated to the client. Views that one therapy is more effective than another must be challenged. This may promote an openness to hear from clients what they feel their needs from therapy are, helping to establish a relationship that is collaborative.

• **The factors in successful therapy**
The research suggests that one of the key factors in the success of the therapeutic process is the ability of the therapist to connect or ‘engage’ with the young person. Clinicians must be aware of the young person’s need to
experience hope for the future and trust in the client-to-clinician relationship. Future hope is successfully attained and sustained through the development of a trusting and safe relationship between client and clinician.

- **The importance of interventions reflecting a systemic approach**
  Comments from caregivers describing the effects of a young person’s depression on the whole family sets a challenge to services to ensure that a systems’ approach to service delivery is followed, and the impact of mental health difficulties such as depression are viewed in a systemic manner.

- **Clinicians informing young people about medication**
  If medication is to be considered as an option for a young person, clinicians need to be aware that when young people are depressed, their ability to receive and retain information may be affected. Information should be given more than once, in addition to being offered to other supports and in written form.

- **A changing sense of self during recovery and the effects on caregiver and clinician relationships**
  Caregivers and clinicians need to be aware that when a young person is recovering from depression they may find it difficult to accommodate to their altering sense of self. This may result in a reluctance to continue with therapy. It is possible that they will discontinue with any therapy that has been commenced. If this is to be avoided, caregivers and clinicians must be able to use their relationship to address this issue with the young person in their care, and to actively support the young person throughout the process of recovery.

- **Clinicians preparing young people to leave the service**
  As mental health services are funded to provide care for discrete periods of time, a challenge exists to services to inform young people of the process of both completion of contact and options for future contact at an earlier point in the therapy process, recognising the significance of the relationships that develop between the young person and the clinician.
Concluding Comments

These findings support the thesis that the three recurring themes that need to be addressed by clinicians if young people are to be offered support in their experience of depression are:

(i) the sense of powerlessness the young people bring with them to therapy which results from their lowered self-esteem and altered concept of self;

(ii) the experience of stigma attached to mental illness and mental health services;

(iii) the effects of the experience of depression on the young person’s understanding of self.
6.1: An Introduction: The Contribution Made By This Research

This thesis extends the understanding of depression during adolescence. Quantitative studies have provided profiles of depression from an adult perspective such as the DSM-IV (1994). Two qualitative studies have explored young people's beliefs and concerns about mental health (Moore, 1996; Young, 1997), but neither contributed specifically to the review or development of intervention strategies for young people experiencing depression.

Two sets of guidelines for the treatment and management of depression that are currently in circulation (National Health Committee, 1996; Poling, 1997) provide specific groups (primary health-professionals and families respectively) with information on the identification of depression and the treatment resources available. Their discussion is limited to information that is primarily based on the DSM-IV (1994). Both resources have been prepared almost exclusively for the treatment and management of depression during adulthood.

This study extends this information by analysing the experience of young people who have been depressed. This new information was gathered by interviewing depressed young people and their caregivers and led to a fuller understanding of the experience of depression during adolescence.

I have highlighted the importance of designing research that includes the 'voice' of disadvantaged groups, so that they can be included in decision-making in areas that directly affect them, such as intervention development. I want to send a strong message to other researchers that more of this research is required, for as my research has shown, this is a very valuable research method that extends knowledge, yet to date has been under-utilised.
6.2: The Value for Participants in Using this Method: Research as Therapy

In this study it was clear that the participants felt that they had benefited from the research process. During the data collection I noticed that most of the participants attended their interviews promptly and I sensed that they gave of themselves willingly, offering what I considered to be excellent and extensive information. Despite this, I was surprised by some of their comments during their final interviews:

**Ella:** 'The meetings were really helpful in making sense of what has been happening to me'.

**Emily:** 'I looked forward to doing this because I enjoyed talking to you for all those hours, you had the time to listen to all of it'.

**Suzie:** 'It was really enlightening to look at it all again and understand it some more'.

**Lachlan:** 'Being listened to was cool, you made me think'.

As I reflected on these comments I realised that for some of the young people, there appeared to have been some positive and potentially therapeutic consequences that resulted from their participation in this research.

It has been suggested by Howe (1996) that the qualitative method of research by its very nature has some unintended and perhaps inevitable (although not unwelcome) therapeutic value. In their discussion of the therapeutic value of qualitative research, Hart and Crawford-Wright (1999) noted that there are some common elements of a research interview and a therapeutic encounter. For example, both types of interview involve the sharing of personal events. The listener, in this case the researcher, attempts to understand this information by clarifying, probing and paraphrasing the conversation in much the same way as would a counsellor. As the researcher, I placed a significant importance on engaging with participants, encouraging a relationship that was safe and one that was viewed by the participants as exclusive. From the comments above, it is clear that at least some of these participants then felt empowered to offer their views.
A similar therapeutic outcome for participants was described during a presentation of the findings of the Canterbury Suicide Project (Beautrais, 1998). The presenter stated that the group in the study who had made serious suicide attempts and were followed by the study's researchers over many months, reported that they had found their participation in the research to be an important part of their healing process. The presenter believed that this feedback resulted from several factors which included the relationship that the researchers had developed with the participants, the willingness of the researchers to be accessible by meeting in environments chosen by the participants, and the participants' belief that they were assisting others by participating in the research.

I propose that as for the participants in the Canterbury Suicide Project there was another important part of the research process that may have influenced the therapeutic outcome for participants in this research. This was the participants’ belief that their voices were enabling other young people with similar difficulties to be helped.

The idea that there may be personal gain from helping others, has been used by White and Epston to develop the concept of ‘consulting your consultants’ (Epston & White, 1992, p.11). They suggest that when clients believe that they hold valuable information that will help themselves, their therapist, and other people with similar difficulties, then they place themselves in a position of ‘authority’ (Epston & White, 1992, p.17). This is a position that provides them with a more equal status in the therapist-to-client relationship. The clients’ increase in self-confidence and improved sense of self helps them to believe that they can find solutions to their problems. In effect the participants in this research have become consultants to themselves, the researcher, and other young people experiencing depression. This position has empowered them to feel more equal and confident in their relationship with the researcher, and has allowed them the freedom to explore interventions for their difficulties.
An implication for future research is the recognition that designing research of this nature must take into consideration the potential therapeutic value for participants of the individual interview process. Thought needs to be given to ways of maximising this effect to enhance positive outcomes. For example: could research interviews be included as a regular part of a depressed adolescent’s therapy, especially during the latter stages of recovery?

6.3: Findings: The Bigger Picture

6.3.1: The Role of Communication in the Development of Depression

In Chapter One I described the current understanding on how depression develops. Most of the writers that I reviewed believe that there is no one explanation. Rather, it is thought that the cause of depression is multi-faceted (Watkins, 1995). One of the factors that is thought to be important in the development of depression during adolescence, is the interpersonal interactions of the young person. When a young person is depressed, the way they feel about themselves is reinforced by their interpretations of their interactions (Joiner, Coyne & Blalock, 1999; Klerman et al., 1984).

From my reading of the literature and my analysis of the data, important understandings emerged:

(i) Adolescence is a period of transition and there are a number of tasks to achieve. Depression interrupts the developmental process by lowering self-esteem and altering the perception of self. This in turn affects the young person’s development of social competence and delays the task of individuation from parents.

(ii) During the process of individuation young people attempt to re-negotiate the relationship they have with parents, seeking further independence and building meaningful relationships with peers. Depression can interfere with this process,
complicating communication between young people, their families and their peers. This may result in social isolation which increases their experience of hopelessness, powerlessness and separation from others. The changes in communication which are attributed to depression may create confusion for family and friends, leaving them bewildered about what is happening and what to expect. This adds to the young person's sense of isolation. This can lead to an escalation in the young person's experience of depression and an interruption to the development of social competence. The young person is then left further behind their peers and their interpersonal relationships are potentially affected in a long-term or permanent way.

6.3.2: The Role of Communication in ‘Recovery’
My research has shown the importance of a young person’s interpersonal interactions with others and how their interpretations of these interactions have contributed to their experience of depression. This establishes communication as an integral aspect of depression.

My research suggests that there may be an opportunity to influence the young person’s interactions with others, so that these interactions support the young person’s recovery from depression. Consequently it may be beneficial for those who provide support to young people with depression, to understand the types of interaction that the young person would find most helpful. They could then use this information to support the young person’s recovery.

An analysis of the young person’s descriptions of their interactions with others revealed that there were many references to experiences of stigma and powerlessness in their relationships, both of which contributed to their altered sense of self. It was clear that these experiences created barriers to positive communication with caregivers, peers and health professionals and therefore, barriers to the healing process. From this understanding I was able to identify
what young people found helpful and unhelpful during their recovery from depression.

This allowed me to suggest intervention strategies for the three groups of people the participants identified as integral to their recovery process: peers, families and health professionals (see Chapters Three, Four, and Five). All three are well positioned to effectively support young people experiencing depression and promote their healing.

6.3.3: The Importance of Therapeutic Relationships to ‘Recovery’

The intervention strategies that have been suggested in the preceding chapters have been informed by the notion that increasing effective communication enhances healing. Common to all these strategies, is a recognition that recovery is dependent upon supportive interpersonal relationships. I would argue that where these relationships support recovery, they become “therapeutic relationships”.

Definitions of therapeutic relationships can be found in the literature on counselling and psychotherapy (for examples see Rogers, 1958; Truax & Carkuff, 1967). Rogers (1958) defines a therapeutic relationship as:

\[
A \text{ relationship in which at least one of the parties has the intent of promoting the growth, development, maturity, improved functioning, improved coping with life of the other... (Rogers, 1958, p.6).}
\]

The literature suggests that therapeutic relationships rely upon a number of features linked to both clients and clinicians (Belkin, 1988). If a therapeutic relationship is to develop, the clinician needs to be able to connect with the client, to be able to listen, and to find out what they want. The client needs to feel accepted and heard by the clinician. These elements have been described by Rogers in his description of ‘Client-Centred Therapy’ (Rogers, in Kirschenbaum & Henderson, 1989, p.137). Furthermore, the relationship between the client
and the clinician is more important than the theoretical orientation and associated
techniques practiced by the clinician (Masson & O'Byrne, 1984). The
understanding that is gained by the clinician through listening to the subjective
accounts of the client promotes the development of specific intervention
strategies.

Continuing his discussion, Rogers (1958) supports the notion that therapeutic
relationships can occur beyond the therapist-to-client relationship dyad.
According to Rogers:

... It [a therapeutic relationship] would certainly include the
relationship between mother and child, father and child,
physician and patient... Counsellor and client... Group-
leader and his group... Community-consultant to a
community group (Rogers, 1958, p.6).

It was clear from the analysis of the young people's descriptions of their
relationships with caregivers and peers that there were elements of therapeutic
relationships. For example:

- the young people felt listened to and heard;
- they were able to trust the other person;
- they sensed that the other person wanted to understand their experience;
- support was mostly unwavering;
- they sensed there was a genuine interest in their well-being and that others
  wanted to help.

6.3.4: Applying the Relationship Principle to Counter Stigma and
Powerlessness
By applying the principle that therapeutic relationships are important to
recovery, it is possible to identify strategies to counter the effects of two of the
debilitating experiences described by the young people: stigma and
powerlessness.
(i) Countering Stigma

As outlined in Chapter Two, the literature suggests that people with mental health difficulties are relegated to a deviant status by society. As a result they experience isolation and powerlessness (Crocker & Major, 1989). Negative societal images of people with mental health difficulties and psychiatric institutions encourage the stigmatising beliefs that have developed over time. These beliefs are reinforced by the media resulting in ignorance and fear (Ashmore, 1975; Rosen, 1985; Waite, 1985). People with mental health difficulties continue, even today, to be marginalised (Smith, 1996).

Efforts to counteract stigma need to be applied at two levels: (a) a personal level, and (b) a societal level.

(a) At a personal level

For the participants in this study, being labeled as depressed was seen as both a positive and a negative experience. The role of the clinician was important in this experience. For example:

- the participants reported that being told that they were depressed was a helpful experience when the clinician was able to expand upon the diagnosis. They did this by giving information on what the experience of depression was like, its treatment and potential outcomes, what to tell or not tell others, and what to expect from telling. As this important and practical information is not currently available in the literature, the clinician’s information is likely to have been gained from listening to the experiences of other young people who have been identified as depressed; however:

- being labeled as depressed was seen as a negative experience when they were given information by clinicians that inspired hope and set up expectations that were not met.
I suggest that when a young person has been experiencing unwanted changes that have resulted from a mental health difficulty such as depression, being told that they are experiencing a legitimate illness for which there are treatments available fosters hope. This may overshadow some of their concern that they will be ostracised by others because of the diagnosis of clinical depression, and their attendance at a mental health service.

If the expected outcomes from the interventions offered by the clinician are not met, the young person may feel disillusioned with the clinician and their attendance at the mental health service. This disillusionment may lead to a loss of hope and promotes the negative thinking which has been seen to be a significant feature of depression.

A link is therefore established between the ability of the clinician to use their relationship with the young person to establish hopeful, but realistic expectations and to offer useful and practical information (as an example, how to counter stigmatisation) and the recovery of the young person from depression.

The ability of a young person to manage the effects of social stigma is therefore heavily dependent upon the therapeutic interaction with their clinician. The clinician’s skill in describing an intervention strategy which helps young people to identify who to tell that they are depressed, when, and how much to tell is an example of this.

(b) In society at large

The effects of societal stigmatisation are reported as being one of the most significant barriers to recovery from mental health difficulties (Collings & Ellis, 1997).

The literature suggests that education is one of the key interventions to challenge the societal stigma attached to mental health difficulties (Collings & Ellis, 1997). I believe that before it is possible to offer an educational approach, an
understanding of the meaning individuals attach to this experience is required. This relies upon interpersonal relationships, where people who have had these experiences feel empowered to talk about them. Information can be collected that could then be used to challenge and educate the people in society who hold the most stigmatising beliefs.

It would be important to have assessed the most effective way of delivering this information, so that it is heard and received by the people who need it the most, since these beliefs will have developed over time and are likely to be deeply entrenched. Given that the media have been implicated in the development and maintenance of stigmatising beliefs about mental health difficulties, it follows that to be successful, any educational process must also involve the media. Examples would be targeting personnel such as film makers and news people to deliver information that challenges negative attitudes, recognises dubious reporting and encourages positive change.

A national anti-discrimination campaign has commenced in New Zealand which uses the media as one of the means by which stigma can be addressed (Mental Health Commission, 1998). The challenge will be to accept that changing public attitudes will be difficult and will take time. Therefore, adequate funding to accomplish this change must be made available for a sufficient length of time.

(ii) Countering Powerlessness
Throughout this research, the most overwhelming experience described by the participants was their sense of powerlessness. During my contact with both the participants and their caregivers I was aware of their sense of hopelessness, helplessness and frustration, all of which were connected with their sense of powerlessness to alter their situation.

From the young people’s descriptions, the powerlessness they experienced appeared to be related to their low self-esteem and altered sense of self which were a part of their experience of depression. This resulted in what I interpreted
as a one-down position in their interpersonal relationships, further disrupting their communication with others. This was most present in their relationships with peers and health-professionals.

A one-down relationship with their peers resulted in the young people’s sense of isolation, and separation from their peers. For some participants this was accentuated when peers held stigmatising beliefs about mental health difficulties or attending mental health services.

A one-down relationship with clinicians resulted in the participants’ inability to articulate their needs clearly. This meant that any therapeutic process relied upon the ability of the clinician to recognise and understand the young person’s needs in order to successfully respond to them.

The one-down dynamic present in the young people’s relationships with peers and health professionals was less clear in their relationships with caregivers and family. This was explained by some of the participants as resulting from their perception of the relationships they held with family, viewing family as an extension of themselves. When they were significantly depressed, they viewed their families as a part of who they were, and by association were, therefore, no-good and contaminated by depression. The net result however, was a sense of isolation, distance, and alone-ness, just as it was with peers and health professionals.

The therapeutic relationship is the vehicle for addressing the experience of powerlessness in all of the young person’s interpersonal relationships. For example, the ability of the clinician to successfully engage with the young person, is critical to the process of understanding their needs and providing an environment in which they can be addressed.

Caregivers and peers also have a significant role in countering the experience of powerlessness through their therapeutic relationships with young people
experiencing depression. It is likely to be the role of clinicians in mental health services to promote an awareness of how integral relationships with caregivers and peers are to recovery, and how these can be supported so that there can be a continuance of social contact, even if this contact is experienced as different than it was prior to the onset of depression.

Clinicians can also support caregivers and peers by educating them to understand the behaviours exhibited by the young person experiencing depression. An understanding of depression and its effects on interpersonal relationships will encourage caregivers and peers to know how to support young people experiencing depression and encourage the development of therapeutic relationships integral to recovery.

6.4: Chapter Six: Concluding Comments

In the introduction to this thesis I posed the question: How do young people interpret and describe their experience of depression and what can I as a mental health worker learn from this?

Through the process of interviewing eleven young people who were recovering from depression, and their caregivers, I made several discoveries:

(i) that the experience of depression is far more complex than can be understood by relying upon a diagnostic schedule such as the DSM-IV (1994) to provide this understanding;

(ii) that the way a young person experiences depression will depend upon many contextual factors that must be explored before intervention strategies can be developed;
(iii) that the context in which a young person develops and recovers from depression can be most usefully explored by examining the interpersonal interactions between a young person and the people in their environment.

I identified three central experiences which became the key themes of this research. The first two were the young people's sense of powerlessness, and their experience of stigma. Both of these were underpinned by the third experience, their altered sense of self; which appeared to be a direct result of the process of depression.

It was clear during our contact, that the way that the young people experienced depression was linked to their interactions with others. Important relationships were identified as being with caregivers, peers and health professionals. By interpreting the young people's and caregivers' descriptions of these relationships I was able to make a number of suggestions that I have described as intervention strategies, these being located at the end of Chapters Three, Four and Five.

In Chapter Three: Relationships with Caregivers, important findings included that:

- marital separation was identified as one of the most significant events for the participants in spite of many other factors such as physical abuse and death of a parent;
- as depression may continue for many months or even years, the family of a young person with depression is required to make many adaptations in order to continue to function. All family members are affected by a young person's depression. This has been likened to a grief process that runs in parallel to the young person's experience of depression.

In Chapter Four: Relationships with Peers, important findings included that:

- peers were identified as providing an important source of support for the young people during their recovery. Often these people would be poorly
resourced to provide support and because of this their support could not always be sustained over time. An important role for health professionals is, therefore, educating and supporting peers in this supporting role.

In Chapter Five: Relationships with Health Professionals, important findings included that they have an important role in:

- being aware of the significance of their contact with young people experiencing depression and therefore being clear about the expectations of any intervention that is offered, be it therapy or medication;
- providing an environment for young people where an early connection can be established in their relationship, paying attention to issues of match, confidentiality, and clarity of the therapy process;
- challenging stigma at an individual and societal level.

One of the most significant suggestions that I have made in this thesis is that by maintaining the integrity of the interpersonal relationships of a young person experiencing depression, recovery is enhanced. Every attempt needs to be made to prevent negative changes in the interpersonal functioning of the young person experiencing depression. This research has indicated these changes may result in the alteration of self-esteem and of self-concept affecting the development of social competence and disrupting the young person’s journey to adulthood. By supporting young people through relationships that are by their nature therapeutic, communication is enhanced, needs are identified and recovery is possible.
REFERENCES.


The Experience of Depression During Adolescence:
Research Information Sheet

You are invited to take part in a study of young people’s experience of depression. The study aims to describe how young people experience being depressed. This information will be used to ensure other people are aware of the impact depression might have on the life of a young person.

There are 3 things that will be requested of you. You may not agree to all 3, and your participation in any or all parts will be greatly appreciated.

The 3 requests are:
1. Participation in a group-meeting of no more than 5 young people who have been depressed. It may be necessary for the group to meet more than once, but no more than three times. Each meeting will last about 2 hours. You will be provided with drinks and snacks. At the meeting(s), the facilitator will ask people in the group a number of questions about their experience of depression.

2. Following the group meeting(s), you will be asked to meet with the group facilitator for approximately an hour each month for 6 months. These meetings will involve only you and the group facilitator, although you will be welcome to bring someone along as a support person if you wish to do so. You will again be asked some questions about depression and what being depressed has been like for you.

3. Your agreement to allow the researcher to have a 1-off meeting with your parent(s) or caregiver where they would be asked similar questions to you about the time you were depressed. If you would like a copy of the questions they will be asked, this will be supplied to you.

All the meetings will be audiotaped, but you can be assured of your confidentiality when the information you or your parent(s)/caregiver has given is used by the researcher. The tapes will be kept by the researcher until the study is completed and then they will be destroyed. Your name will not appear anywhere in the research report.

You might want a written summary of the results. If so, this will be forwarded to you.

If any of the meetings become difficult for you at any stage, either during or afterwards, you may-

1) Refuse to answer specific questions.
2) Withdraw from the meeting.
3) Talk to your support person (this may be your parent or caregiver, or may be your case manager at the Youth Specialty Service).

The study is being conducted by Bronwyn Dunnachie who can be contacted at telephone 339 1126.

I will be happy to discuss any questions you may have about participating in the study.

The study has been approved by the Human Ethics Committee, University of Canterbury and by the Southern Health Authority Ethics Committee (Canterbury).

It is being supervised by Dr. Bob Manthei and Ms. Missy Morton, Education Department, University of Canterbury. They can be contacted at telephone 364 2546.

If you have any queries or concerns regarding your rights as a participant in this research, you may wish to contact the Advocacy Service, Healthlink South, telephone 377 7501 Thank you.
CONSENT FORM

I have read and understood the description of the study that aims to gain a better understanding of how young people experience depression. On this basis, I agree to participate in the study.

I also give/do not give (delete as appropriate) my written permission for my parent(s)/caregiver (please write their name here:),
to be involved in the study, with the understanding that he/she will be interviewed once only, and I will be able to view a copy of the questions to be asked during this interview before giving my written consent.

I will be given a copy of this consent form.

I consent to the publication of the results of the study with the understanding that my anonymity will be preserved. I understand also that I may withdraw from the study at any time including the withdrawal of any information I may have already provided.

I understand that this study has received ethical approval from the Canterbury Ethics Committee and the Human Ethics Committee, Canterbury University.

SIGNED (THE PARTICIPANT).  DATE

WITNESS OF THE PARTICIPANT'S CHOICE.  DATE.

RESEARCHER.  DATE

I WISH TO RECEIVE A WRITTEN SUMMARY OF THE RESULTS OF THIS STUDY:

YES / NO.
THE EXPERIENCE OF DEPRESSION DURING ADOLESCENCE

RESEARCH INFORMATION SHEET (CAREGIVER):

You are invited to take part in a study investigating young people's experience of depression. Your involvement in the study will be one interview of approximately one hour in duration. There will be several questions asked of you by the interviewer which will be based on your understanding of the depression the young person in your care has experienced.

The interviewer will make an audiotape of the interview, after receiving your written consent, and the written consent of the young person in your care.

If the interview becomes difficult for you at any stage, either during the interview or after the interview has occurred, you may:

1) refuse to answer specific questions,
2) withdraw from the interview.

The results of the study may be published, but you may be assured of the complete confidentiality of information gathered during the study. Your identity will not be made public at any stage of the study.

The tapes will be destroyed when the study is completed. A written copy of the findings will be forwarded to you at your request.

The study is being conducted by Bronwyn Dunnachie who can be contacted at telephone 339 1126. I will be happy to discuss any concerns you may have about participating in the study.

The study has been approved by the Human Ethics Committee, University of Canterbury and by the Southern Health Authority Ethics Committee (Canterbury). It is being supervised by:

Dr. Bob Manthei and Ms. Missy Morton, Education Department, University of Canterbury. They can be contacted at telephone 364 2546.

If you have any queries or concerns regarding your rights as a participant in this research, you may wish to contact the Advocacy Service, Healthlink South, telephone 377 7501.

Thank you for your assistance.
YOUTH AND DEPRESSION STUDY.

CONSENT FORM (CAREGIVER)

I have read and understood the description of the study that aims to gain a better understanding of how young people experience depression. On this basis, I agree to participate as a subject in the study, understanding that permission for my participation has already been obtained from the young person in my care.

I understand that I will be able to view a written copy of the questions to be asked during this interview before giving my written consent.

I consent to the publication of my results of the study with the understanding that my anonymity will be preserved. I understand also that I may withdraw from the study at any time including the withdrawal of any information I may have already provided.

I understand that this study has received approval from the Canterbury Ethics Committee, and the Human Ethics Committee, Canterbury University.

SIGNED (THE PARTICIPANT). DATE.

WITNESS OF THE PARTICIPANT'S CHOICE. DATE.

RESEARCHER. DATE.

I WISH TO RECEIVE A SUMMARY OF THE RESULTS OF THIS STUDY: YES/ NO.
29 October 1996

Ms B Dunnachie-McNatty
C/- Ms M Morton/Dr Manthei
Department of Education
UNIVERSITY OF CANTERBURY

Dear Ms Dunnachie-McNatty

The Human Ethics Committee advises that your research proposal “Wading through a pit of mud: the experience of depression during adolescence” has been considered and approved. However, the Committee notes that your supervisors may require access to the data.

Yours sincerely

J A Cockle (Miss)
Secretary
10 December 1996

Bronwyn M Dunnachie
50 Moncks Spur Road
Redcliffs
CHRISTCHURCH

Dear Bronwyn

Youth and Depression
Investigator: Bronwyn Dunnachie
Protocol number: 95/05/078

Thank you for your letter of 3 December enclosing revised information sheets and consent forms.

These are now satisfactory and approval is finalised. I look forward to receiving your report on the completion of your extension.

Good luck with your project.

Yours sincerely

Sally Cook
Ethics Committee Administrator
31 July 1996

The Head of Education Department
University of Canterbury
University Drive
Ilam
CHRISTCHURCH

Dear Sir/Madam

re: BRONWYN DUNNACHIE-McNATTY

This is to confirm that both Dr Brian Craig, Clinical Director and myself as Unit Manager of the Youth Specialty Service, strongly support Bronwyn's planned research in the area of Youth and Depression.

More specifically our support will include provision to negotiate appropriate study leave and access to subjects following Ethics approval. Given our diverse multi-disciplinary team, more support from other team members can also be expected.

Yours faithfully

[Signatures]

Dr Brian Craig
Consultant Psychiatrist

Daryle Deering
Unit Manager
CODING CATEGORIES.

SETTING / CONTEXT CODES:

HOME,
A MENTAL HEALTH SERVICE: THE BIN, THAT LOONY PLACE,
HOSPITAL,
SCHOOL,
WITH MATES,
AWAY FROM IT,
NOT AROUND.

DEFINITION OF THE SITUATION CODES:

IMAGE OF PRESENT SELF: CHANGING, NEGATIVE, GETTING BETTER,
IMAGE OF PAST SELF,
IMAGE OF FUTURE SELF: I’LL NEVER BE THE SAME.
IMAGE OF SELF WHEN DEPRESSED: NEGATIVE THOUGHTS, NIF, LOSER, OUT OF IT, LOSING IT.

PERSPECTIVES HELD BY PARTICIPANTS:

YOU CAN’T PUT IT INTO WORDS,
FEELING CHANGED,
OUT OF MYSELF,
THE STRUGGLE,
ACTING.

GREAT EXPECTATIONS,
DIFFERING UNDERSTANDINGS,
NON-INTRUSIVE PRESENCE,
DISCONNECTEDNESS,
SPIRALLING DOWN,
MEDICATION: TO TAKE OR NOT TO TAKE,
UNIQUE AND ALONE,
THE VIOGUS CYCLE,
AMBIVALENCE,
HELPLESSNESS,
CONFUSION,
SELF-BLAME,
FEAR,
EMBARRASSMENT.

CAREGIVERS PERSPECTIVES:
WALKING ON EGGSHELLS,
THE STRUGGLE, LOSING FRIENDS,
MISSING OUT,
JUGGLING,
SELF-BLAME.

WAYS OF THINKING ABOUT PEOPLE AND OBJECTS:
PSYCHOS.
LOONIES.
NUTTERS.
DRUGGIES,
THE OLD MAN,
THE PILLS.
THE PITS.

PROCESS ORDERING LIFE-HISTORIES:
BEFORE DEPRESSION,
DURING DEPRESSION,
RECOVERING FROM DEPRESSION.

ACTIVITY CODES:
ATTENDING A MENTAL HEALTH SERVICE,
AT SCHOOL,
BEING WITH FAMILY,
TAKING PILLS,
SELF-CARE,
IMPROVING / GETTING BETTER.

EVENT CODES:
SUICIDE ATTEMPTS,
SELF-HARM,
LEAVING SCHOOL.

PARALLEL EXPERIENCES.

PARENTS SEPARATING,

BECOMING A TEENAGER (CAREGIVERS),

PARENTING A YOUNG PERSON WITH DEPRESSION.

STRATEGY CODES:

MANAGING DEPRESSION (CAREGIVER),

MANAGING DEPRESSION (YOUNG-PERSON),

MANAGING SUICIDALITY,

MANAGING SELF-HARM,

MANAGING ATTENDING A MENTAL HEALTH SERVICE,

SELF-CARE.

RELATIONSHIPS AND SOCIAL STRUCTURE:

RELATIONSHIPS WITH PEERS,

RELATIONSHIPS WITH CAREGIVERS,

RELATIONSHIPS WITH HEALTH PROFESSIONALS.