Women and Depression

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Edited by

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FOREWORD

IFFAT HUSSAIN

According to the World Health Organisation (WHO), "depression is not only the most common women's mental health problem, but may be more persistent in women than men."[1] The WHO has estimated that by the year 2020, depression will be the second most common disability causing disease in the world.

Depression is complex in relation to other symptoms. It falls in various categories: it may be a psychiatric illness, a syndrome, a symptom, a sustained change in affect, or a transient mood. When it is excessive and persistent and may result in a loss of contact with reality, then it is considered a psychiatric disorder.

The symptoms and diagnosis of depression are more prevalent in women than in men. The evidence shows that depressed individuals are less productive than non-depressed individuals, and throughout the world, rates of depression are greater among females than males. Depression is an illness in which symptoms are primarily physical and psychological with more adverse and distressing complaints. This leads to impairment of work capacity, reduction and lessening of social functioning, the suffering of patients' families if the disorder is prolonged.

This book, *Depression and Women*, is a collection of researched papers and essays from authors, produced in the hope that it will encourage a comprehensive understanding of this condition which is so common among women, and that it will provide an insight into depression to a wide variety of professionals and people outside the medical field. The chapters show different aspects of the phenomenon, taking a broad view of the subject of depression in women. There is also a concentration on interpersonal therapy and counselling for depressive conditions. These

[1] World Health Organisation, Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19–22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

essays are not purely "medically" based: it is also intended to be accessible to those outside the medical field: patients, their families and friends and anyone who is interested in or curious about this condition.

This edited volume on women and depression is multidisciplinary, including cultural, sociological, public health, psychology and psychiatry aspects. As the origins of depression are various and result in a high prevalence of depression in women, this book may lead to further interdisciplinary views on women and depression. I believe that the more we learn, the greater the probability that we can eradicate the debilitating nature of depression in the near future.

Most of the authors contributing to this book *Women and Depression* are women; they have all communicated their professional experience, information and knowledge to make this a valuable book. *Women and Depression* integrates the latest information from women experts in fields including sociology, psychology, psychiatry and public health to address issues concerning depression.

I hope that this book will provide useful information concerning depression in women and also as a paragon for continued international and interdisciplinary research.

I wish success and blissful life to all the women who are suffering from depression, and that those who are beginning their fight against this illness do not let it come between them and a a life full of joy and happiness. I look forward joining them on the path to better and happy lives.

I am very grateful to and appreciative of all the authors who have communicated their valuable work in *Women and Depression*, with the aim to benefit and make this world a joyous place for women with depression. Their work in this book is summarized below.

In "Showing One's Sadness in a Visual Context: Providing a Sense of Community and Support for Depressed Women through Video Interviews," Dr. Irmeli Laitinen and Professor Elizabeth Ettorre report the findings from forty-eight video interviews used in the Women and Depression Project (WDP) in Finland (Laitinen, 2008; Laitinen & Ettorre, 2004, 2007; Laitinen, Ettorre, & Sutton, 2006, 2007). The video work used in this project incorporates narrative interviews and is embedded in oralysis. Videos provide participants with mirror images of themselves: with this the researchers and participants developed short-term, therapeutic interventions in order to provide a sense of community and support for marginalised, depressed women. Dr. Laitinen and Professor Ettore also generated an action-research approach for depressed women and gathered valuable data concerning women's experiences of depression.

In their essay "The Role of Community-Based Groups in the Prevention and Recovery of Postnatal Depression," Shari Read and Debra Rickwood examine the role of group membership with regard to positive mental-health outcomes for women with young children. Specifically, they explore whether community-based groups provide aspects of prevention and health promotion in supporting otherwise isolated stay-at-home mums with young children. The research employed a questionnaire-based survey of three groups of women: those who participate in a community-based women's group, women who participate in one of a number of ACT playgroups, and stay-at-home mums who were not participating in a parenting-related community group at the time of the research. Analysis compared each of the research groups on measures of social-connectedness, group-belonging and support, resilience and postnatal depression.

Dr Tracie O'Keefe illustrates four women's cases in "Overcoming Depression and Female Learned Helplessness through Hypnotherapy," describing how they were able to overcome their depression by learning a greater sense of self-efficacy during hypnotherapy. These four women were helped in relation to a sense of depression through hypnotherapeutic intervention and personality alteration. In their own way, they suffered from low self-esteem and poor self-image: this is a common theme found among women who suffer from depressive states for extended periods of time beyond the norm, due to patriarchal cultural ideations.

Kim Davis is a Dru yoga therapist. In her essay she explores why yoga is one of the fastest-growing self-help modalities today—particularly among women suffering depression. Kim discusses the internationally researched evidence supporting the value of yoga in the treatment of depression and explains the specific value of Dru yoga for transforming negative emotional states through gentle therapeutic movements, breathing, positive guided imagery and affirmation.

Dr. Sabin Sabin Fernbacher and Christine Hodge argue in their essay "Childhood Sexual Abuse and Depression—Connections, Theories and Practice Implications within the Primary Care Setting," that primary-care providers often work with women who suffer from depression, but they are not always aware of their clients' history of childhood sexual abuse. They look at this issue and some of the tensions concerning this area of work, such as screening for childhood sexual abuse—"to ask or not to ask"—during the assessment phase. Furthermore, they discuss dilemmas and organisational processes that need to be considered if such inquiry is to be made routine.

In "Depression in African Women," Magnolia Bahle Ngcobo and

Professor Basil J Pillay studied depression in African women attending a health service. Clinical records of female patients presenting with depression at a General Hospital in a densely populated African township were examined over a two-year period. A review of the biographical and epidemiological data of these patients is presented. Depression in these women was related to socioeconomic factors such as poverty, overcrowding, unemployment, high levels of crime, and lack of services and abuse to a considerable degree a relic of the past discriminatory apartheid system.

Iffat Hussain explains the psychological effects and depression in women who are forced to wear veils in "Forced Muslim Religious Seclusion and Veiling for Women and Depression." She comments on this misconception of Islamic practice: the religious seclusion and veiling propagated and preached by Muslim fundamentalists result in a very vulnerable and powerless position for women in the society and in turn may result in depression for women. She explains effects and symptoms of depression these women may show. In addition she adds quotes and complaints of the women against forced veiling and seclusion.

Arts Therapist Belinda Cody presents the case study of a female client who experienced multiple losses following several consecutive significant bereavements. Underlying factors eventually precipitated the onset of a complex period of chronic ill-health and disability, leading to depression. As an alternative to pharmaceutical solutions, the client chose to engage in a range of therapies, according to her needs, from both conventional and emerging therapeutic paradigms**.**

Nancy Moodley and Professor Basil J Pillay present their paper, "Depression in Female Spinal Cord Injured Patients." Their study examines the patients admitted to a provincial spinal rehabilitation unit over the course of one year, most of whom were paraplegic. A semi-structured interview and the Beck's Depression Inventory (BDI) were administered. This study suggests that spinal-cord-injured women experience many losses after the injury and are at a great risk of suffering from depression.

Karen Noonan and Isabelle Ellis write about depression as a symptom of the rare medical condition porphyria. Karen Noonan was herself diagnosed with this condition and discusses her experience of having this disease. Porphyria has been linked with depression and it is said that women display symptoms three times more often than males. The other cases mentioned highlight the fact that this disease is often mis- and under-diagnosed.

In "The Missing Link: Women, Depression and Midlife Transition,"

Robyn Vickers-Willis draws on Jungian psychology and her own research on midlife development to explain why midlife is a time of significant psychological and spiritual development for a woman**,** a time when it is vital for her to embrace her feelings rather than sedate or run away from them if she is to create a personally meaningful second half of life. The essay also considers the impact of the omission of context from much of the current thinking on depression and the role the language of depression plays in women's midlives.

Professor Carolyn Quadrio explains different dimensions of depression in "Psychiatry and Depressed Women," which may be biogenetic, psychological and socio-cultural, and gives multidimensional analysis and reasons explaining why depression is more common in women than men. She provides an overview of factors such as trauma and abuse, biogenetic factors, socio-cultural, political, and economic factors, and psychological factors. She argues that focusing on the relationship of depression to reproductive functions diverts attention from the universal realities of women's lives.

Thank You,

—Iffat Hussain
February 2010

SHOWING ONE'S SADNESS IN A VISUAL CONTEXT: PROVIDING A SENSE OF COMMUNITY AND SUPPORT FOR DEPRESSED WOMEN THROUGH VIDEO INTERVIEWS

IRMELI LAITINEN AND ELIZABETH ETTORRE

Introduction

Depression is a multidimensional, multicultural phenomenon (Bhui & Olajide, 1999; Nazaroo, 1997). To fully understand the embodied material, subjective and discursive aspects of experiences labelled as depression demands drawing upon knowledge that is interdisciplinary (Stoppard, 1997) and sensitive to cultural diversity. The need to recognise the challenge of cultural diversity when analysing depression is important, as emphasised by Falicov (2003), who contends that in contrast to an epidemiological or biomedical approach, a cultural, "ethnographic" one allows us to study the experiences labelled as depression in each society with its own beliefs and meaning systems. Western constructions of depression vary and can be viewed as locally constructed and dependent upon circumstances and environment as well as other social factors.

The purpose of this paper is to report on findings from forty-eight video interviews used in the Women and Depression Project (WDP) in Finland (See Laitinen, 2008; Laitinen & Ettorre, 2004, 2007; Laitinen, Ettorre & Sutton, 2006, 2007). While some may argue that the video could do for psychology and the social sciences what the microscope has done for medicine (Biggs, 1983: 91), the use of videos can be seen as a *bona fide* qualitative research method (Loizos, 2000). The technique of video recording is quite common in therapeutic settings (Rennie, 1994; Angus & Rennie, 1989) and in these settings a video allows a patient to observe him/herself as others see them (Hosford & Mills, 1983). It enables patients to learn what they don't know about themselves but what is known to

others (McCrea, 1983: 95). Videos provide them with mirror images of themselves.

The video work used in this project incorporates narrative interviews and is embedded in what Ulmer (1989) calls oralysis. For example, as researchers seek new ways of understanding and reporting data, oralysis refers to

> the way in which oral forms, derived from everyday life, are, with the recording powers of video, applied to the analytical tasks associated with literate forms. (Ulmer, 1989: ix)

In oralysis, the traditional product of interviewing, talk, is coupled with the visual, providing a visualised audio product consonant with a society that is dominated by the television medium (Ulmer, 1989).

Videos have been used increasingly as a data-gathering tool in social research (Dowrick & Biggs, 1983; Ball & Smith, 1992; Bauer & Gaskill, 2000; Emmison & Smith, 2000; Harper, 2000; Holliday, 2000). In social research, it has evolved in health services as well as other disciplines (Bottorff, 1994), and has been a useful method for recording human interaction in natural settings (Goodwin, 1993) and in working settings where one observes a web of social interactions and activities (Bodker, 1996). Gilgun (1992) has argued that video recording allows theory-generating processes to develop.

The aim of WDP was threefold: 1) to develop a short-term, therapeutic intervention in order to provide a sense of community and support for marginalised, depressed women; 2) to generate an action research approach for depressed women; and 3) to gather valuable data concerning women's experiences of depression.

Methods

With both therapeutic and research aims, therapy was utilised in group work with depressed women recruited from community settings. The target population was adult women who had defined themselves as being depressed and/or had been treated for clinical depression (i.e. defined by a treater as clinically depressed), and who wanted to participate in ten group meetings with other women who were depressed. Group members were recruited at least two months before a group began, mainly through leaflets advertising the group. Eleven groups were organised in three Finnish cities for five years from 1994 to 1999 and they were held both in public and private health care settings located in urban centres. The final study population consisted of 101 women with an average age of forty.

There were a variety of ways in which both qualitative and quantitative data were collected from members during the group process. These included: a pre-group interview, questionnaire 1 (Q1), health diaries, questionnaire 2 (Q2), first video interview, second video interview, questionnaire 3 (Q3), group leader's narrative accounts and group leader's diary. The rationale for the use of varied data collection techniques was to generate an awareness of the complexities of the group process and to ensure that a multi-level approach to data gathering on both an individual and collective level was maintained. Not all methods were used for each group. This was for developmental (i.e. the data collection techniques were being developed at the time and not yet used in a particular group) and logistic (i.e. the first author was not the main facilitator in some groups based outside the original catchment area) reasons. This paper will report only on findings from the video interviews.

Linking a therapeutic program with action research. In action research, the researcher gives results back to service providers. In this type of research, researchers employ a multi-method approach, continually process activities and changes, and document these activities in order to identify issues that might have an impact on service delivery. The first author and main researcher on the WDP developed a process of working within action research which uses criteria such as problem solving, collaboration, participation and self-evaluation. As action research as well as a therapeutic programme, the WDP was flexible and involved a continual evaluation of the therapeutic strategies and research measurements which were used.

The therapeutic programme. WDP offered a time-limited (i.e. ten one hour and forty-five minute group sessions over ten weeks) therapeutic group program for depressed women and included a series of thirty therapeutic exercises. Groups gave members the opportunity to learn communication skills, which helped them to value self-help, mutual support and a sense of themselves as women. While the focus of each session was on a particular topic, self-help techniques were learned through various exercises. Besides the weekly group sessions, a follow-up session was held one year after the group finished. While a therapeutic aim of WDP was to effect positive change with a beneficial impact on women's experience of depression, the purpose of the follow-up was to assess this overall aim by gathering information concerning members' well-being. Two experienced female group leaders led the groups. Prior to participation in the group, the key researcher trained group leaders.

Key therapeutic questions were asked, which included:

- How do depressed women experience depression?

- What kinds of symptoms do they perceive in their lives?
- What life-events, feelings and activities do they link with their depression?
- What kinds of social supports and other forms of treatments (including prescribed drugs) do they encounter while depressed?
- What kinds of changes do they want in their lives?
- Most importantly, is it possible for depressed women who have traditionally been dealt with as objects of treatment to become active subjects in healing their depression?

It was hoped that this research would provide an exploratory method in order to assess whether or not groups are able to help women cope more effectively with depression than if left to their own devices.

Video Interviews

The first author, having used this technique in her family therapy work as a psychotherapist, was quite familiar with video interviews as a therapeutic device. In WDP, video interviews were "normal" psychotherapeutic sessions but ones that were video recorded.

First video interview (45 minutes). A semi-structured interview with active listening techniques, reassurance, feedback (Renne et al., 1983: 31) and free association were used to give space for respondents' own voices. Specific questions asked included:

- How do you understand yourself in your life with your difficulties and your troubles?
- Why do you think you have had to lean on professional helpers?
- What do you think of the help you have had here and earlier?
- Have you ever felt yourself to be depressed, and if yes, what was it like for you?

After these questions, women were free to talk and describe their lives in whatever way they wanted. This interview format allowed a respondent to evaluate her current situation, to consider whether or not herself understanding had changed after her involvement in the WDP group and to discuss what had helped her most. In these interviews, respondents described in their own words their experiences of depression. During this interview the camera was focused on both the respondent and researcher.

Second video interview (5 to 15 minutes). A week after the first interview, the respondent and the researcher watched the first video together. After this viewing, the interviewer asked the respondent how she

felt when she was watching the video, and this session was also videoed. In the second recording, the camera was focused on the participant given that she was the only one who gave feedback about the video. The purpose of the second video interview was to give a participant the possibility of seeing herself, her ways of communicating with other people, her communicative style including non-verbal communication (body language, gestures, tone of voice, etc.) and being reflective towards herself.

Sample. Fifty out of 101 respondents had individual video interviews after their group finished, but two of these video interviews failed and were eliminated from the final sample, leaving forty-eight as the total number. These forty-eight respondents who had video interviews were members of five different groups: two groups were in the public sector (n = twenty members) and three groups in the private sector (n = twenty-eight members). Of these forty-eight women, the majority (n = twenty-seven) were working, seven were unemployed and seven were students. Four members were on permanent sick leave, while three were at home. The average age was around forty: eight women were between twenty and twenty-nine, eighteen between thirty and thirty-nine, thirteen women between forty and forty-nine and nine women were between fifty and fifty-nine. Of these forty-eight respondents, three had severe psychiatric problems while ten were having problems coping with their everyday lives.

During the last session of these groups, the group leader gave every group member an envelope, containing notification of the time of her video interview. For the first time since her pre-group interview, the video interview presented the member with an opportunity to have a special therapeutic session with the group leader on her own. Members participated in a video interview at least one to two weeks after the group ended. Here it should be noted that three women were not willing to be recorded by video camera but agreed to be tape-recorded during the time allocated for their video interview.

Data analysis. During the data analysis stage of the research, the author viewed all video interviews twice and some many times in order to register body movements. The relevant interviews were transcribed by the author between November 2000 and March 2001 and key themes were identified. Excerpts from the video interviews will be used in this paper.

Results

First video interview. When members focused on the main problem in their lives (which led them to their depression) in the first video interview,

they gave a variety of answers. Four major problems, troubles or worries were mentioned. These included: 1) troubles with a partner or significant other (n = twenty), 2) problems with work or studies (n = sixteen), 3) problems with herself (n = eight) and worries about other family members (n = 4).

1. Troubles with a partner or significant other (n = 20). Four group members reported that there were in the process of having a divorce. One woman had been trying to separate from her husband for years, but in her interview she said: "I am divorcing; it takes all my strength... I can't do it... I am not able to do it" (Arja, forty-three).

So for this woman she is divorcing and not divorcing at the same time. Three members discovered that their husbands had had a relationship with another woman, while four women experienced domestic violence. Those women who discovered that their husbands had a relationship with another woman said:

> [It is an] awful shock to wake up from a daydream and believe that my husband had another woman, his colleague from his work…I am so bitter and angry...I want to kill him, so to speak. (Elina, 17)

and

> After then last couple of years so many things have been cleared up. I have a feeling I have been cheated by him. I took care of that family. He was working but now I know he wasn't always working. He was with another woman. I packed the suitcases for him and ironed his shirts. I was a servant. (Kirsti, 22)

Two of the women who were victims of domestic violence were afraid to tell to their husbands that they were participating in the WDP group. As a result, they were offered a locked file cabinet in which they were able to leave their diaries and other group materials. They said:

> In the beginning it was love…It has lasted now for nine years… He is very demanding and I got beaten up and my sons were not happy about it when they saw me all black and blue… They did not get along, these kids and this man [stepfather]…and I have to be split up in two pieces …I could not let this relationship go, and of course these boys were very dear to me… (Leila, 47)

and

> I would like to be invisible and as neutral as possible and please everybody like my parents and my husband. So I move along with other people's

> needs and on the other hand I am extremely critical and demanding about what concerns me. (Päivi, 20)

Other women who experienced violence in their homes said:

> I am very insecure and fearful. I have understood that I have a constant fear...of knives... I don't dare use knives because I have these sorts of feelings. My father used to pretend to do suicide. He was laying on the living room couch and threatened to kill himself with that knife... So I have been living in a miserable situation since my childhood and I have thought many times to kill myself. (Meri, 21)

> I am a person that people can manipulate easily. If I have an opinion so I can change my opinions because I am afraid of fights and I give up... My husband is just like my mother. My mother was awful with her mouth, tight with her opinions and had odd rules. (Liisa, 19)

Two women reported that their husbands drank too much alcohol, and for one of these women that was the main reason why they were facing serious economic problems. She said:

> This moment is feeling good because I just received a phone call from a bank and we have gave us a new loan… [The] good point is that when you have big financial problems, he does not have money to drink... (Irma, 37)

Other women who reported relationship problems with their partners spoke about lack of commitment and support from partners. Those who were separating from partners had ambivalent relationships with them.

> I wanted another child and then my husband said if we do it then you must take care of it totally and then I thought I can't do it…then I was very sad for a long time that I cannot have another child… (Leena, 30)

This above participant was already suffering physical stress symptoms relating to her work and domestic duties.

2. Problems with work or studies (n = 16). Problems concerning work varied for respondents. Three women reported that they were unemployed and had been without work for a number of years. Two of them had had a permanent job (for thirteen and twenty-three years, respectively). However, suddenly these two women had felt that they could not work anymore and left their workplaces. Two other respondents had sought treatment because of the sudden loss of their jobs. Both of them were childless, career women for whom work was an important part of their self-image. They were both over fifty years old and mentioned that it was hard to find new

work if one is over forty. One of the women expressed her despair by saying: "I heard in a Swedish television program that women over fifty are antique" (Leena, 24).

The other woman was a famous personality who had regular appearances on a national television programme. For her, losing her job caused not only self-doubt and self-blame, but also immense shame in front other people—including the Finnish public. Her husband took her to see a psychiatric because she had had serious thoughts of killing herself. During her video interview, this woman said that she had felt too depressed to participate fully in the WDP groups. However, the group had helped her to go out from home to meet people and she could meet her old friends again. Other difficulties with work included a woman who was not satisfied with her job (of more than twenty years) and wanted a change (she had a senior post in the Finnish media).

One woman was experiencing burnout as a result of having an alcohol problem as well as marital problems. Another woman had been on three months' stress leave. She said she was working in a male profession and for much of the time, she felt that she was being excluded from her work mates' conversations. She believed that she was discriminated against as well as overlooked during promotion rounds. Another woman was trying to cope with a difficult boss but felt that she could not manage without the support of professional workers in a psychiatric unit and the WDP group.

One woman was on sick leave after having stressful time in her workplace. She felt that she was incapable of doing her work. Her colleagues isolated her and ignored her. She felt totally disabled in her work. She tried to resolve this work problem by trying to commit suicide:

> If I only think of myself, I am annoyed that I was not successful in that (i.e. suicide) and I am so ashamed and embarrassed that even in that I did not succeed just as in so many other things… (Sirkka, 45)

Seven women had various problems with their studies. Five of these women were talented young students from Helsinki University who had no capacity to enjoy their studies. The main reason why they came to the group was the long waiting lists for individual counselling in the student health service.

3. Problems with herself (n = 8). Eight women felt that their main problems were with themselves. Two women complained of loneliness. One said that she lacked any kind of social skills. Another woman said:

> Already in my teenage years I was terribly lonely and alone, and that's how I never learned how to be social even still I am lacking of basic skills how to approach a person. (Sinikka, 52)

Two women were suffering from severe alcohol problems and this was compounded by the fact that both of their husbands were also alcoholics. One woman's problem was that she was angry all of the time. She said about herself:

> Nothing ever changes. My biggest problem in my life is that I am such a hellishly irritating and peevish, ill-tempered human being that it is limiting my everyday life. I have no strength to be what I should be… [like] some kind of mother figure I have in my mind which I would like to be... but no way this kind of lumberjack which I am. I am not at all like that mother image… I don't have even any kind of ability or resources… (Ritva, 50)

Another woman whose problem with herself was that she heard voices said:

> It was difficult especially when these voices came...I felt all the sins of the humankind...that kind of mental pain you can't imagine. If someone would cut off my hand with an axe, it would not hurt so much as I felt in the forest sitting on a tree stump...It was so painful that there were not many roads…or then a death or something else ... (Irma, 54)

4. Worries about other family members (n = 4). Four women reported that their problems were linked to their worries about other family members. These included worries related to: a member's only child had left for summer camp; a member's children were having psychological problems and the recent suicide of a member's father. The last woman sought help after her father had committed the suicide. Her parents were divorced because her father was an alcoholic. She had found her father dead in his house. She felt guilty and depressed after the incident. She said:

> For a month after my Dad's death, I could not do anything...I just felt very empty. I could hardly wake up in the mornings or take my clothes off when I went to bed I felt so awful. Nothing interested me....Day after day was more awful...I could not go lower...I was eating sleeping pills. I had thoughts about what if something would happen to my car like an accident...I did not think of the future at all...I was stuck with one thing...I was in a prison of my own depression...I could not see anything.... (Helena, 75)

For one member, her husband was constantly moving workplaces in different countries and continents. She tried to raise two children and at the same time, finish her studies at university. Recently, she had been diagnosed with cancer. The cancer had been "cured", but during that time she had not received any psychological support.

The second video interview. The second video interview provided respondents with a new way of seeing themselves and evaluating their lives.

Ritva (29) explained that the reason for her present problems is based on her relationship with her child's father, who has been her boyfriend. She sees herself too dependent on him. The problem lies also on that fact that Ritva wants to have a proper family with this man. She sees things about herself that she had never seen. After Ritva watched her first video interview, she said:

> This video should be shown in a primary school for girls as an example of a warning—as a feminist expression of opinion.... "Don't you girls put yourself in this kind of situation!".... But [still] there was everything in my life, which causes me the problems I have....

Then she says:

> I wonder if it is true what Mikko [her child's father] has said that I somehow enjoy suffering...a professional complainer, as he calls me.

At the end of the second video interview, she says:

> I am tired of it...I don't want to go on and on...and I want to get rid of that what any emotions of it...Once for all there are limits to everything...

She is silent and then she starts:

> But, I must say that in that video (the first video that she just watched) there was everything in a nutshell...all the most important things and what causes these problems...I could see things in myself that I have never seen before...

In her feedback video, Pia (thirty-eight) is livelier than in her first video interview. She uses the feedback video to mirror herself and she makes it clear that she needs another person to talk to about herself. She can't talk to her husband, and when she cannot talk to anybody she feels that her life situation has been more chaotic than she observes now in a video. But when she is analyzing herself and tells about it one cannot be

without noticing that she uses passive form when telling about her own life. She wants to be even closer to the interviewer, looks her in the eyes and leans forward, holding her hands on her knees and starts talking after a short silent moment:

> I can see that there is some kind of structure in my life situation. When you are home alone and you don't talk to anybody.... But now when I heard it with my own ears, when I talked here with somebody it feels that there is structure in my life situation and it does not feel so chaotic.... And when one talks to somebody, one notices that some solutions have been made to the one direction or the other.... I could not work at home with my diary...I need people to talk to...I noticed that my life is going awfully lot around my husband.... But this is now in this moment....

Marja (fifty-four) used this video interview to tell the therapist how she has felt earlier and how she feels now. She reflects on her current and past psychological well-being and how she sees herself. She tells about her treatment how she was first disappointed but later found it beneficial. She also tells how she has been depressed and how painful it was for her. She also says that she is happy enough now to enjoy the life and for a long time she has not been happier. Directly after seeing the video, she yawns and smiles and says:

> ...I was actually nervous to come back (and see the video) and in the beginning, it felt really awful but after all, it was fun to look at it.... I thought that it would be much more muddled than it was....

While saying this she waves her hands around in front of her and continues: "...It was so mixed up, but it was all clearly there and one could understand it..." She changes her sitting position to look more assertive, and folds her arms in front of her chest, saying:

> ...I thought to myself that if I would see this woman on television, I would tell her that take yourself by the scruff of your neck and cheer up.... Do something to yourself... [she's] not at all a happy person.... But it is enough for me [in this moment] that I am alive...

She puts her right hand on her chest where about her heart is and says:

> ...I am very satisfied with it [life]...I am able to be satisfied with ordinary life...Like the forest.... Little puddles in the road.... This is my happiest time in my life.... I don't have any pain or anxiety....

She says this with a higher voice, looks at the interviewer straight in her eyes: "...I don't feel awful or depressed.... Even though this may sound [that I was a] very phlegmatic and monotonic person [in that video]...." She nods with her head to the TV monitor and then shows a straight line in front of her with her right hand and lifts her shoulders up: "...but what is healthier than this?" And she smiles at the interviewer.

Helena (25) is young and very conscious of how she looks at herself in her video, reflecting on when she will be older and perhaps wiser, knowing that without any doubt she will be moving on from this moment in her life without knowing yet what direction. She is very optimistic about her future. She did experience a deep depression after her father's death, and now she is satisfied that she is over it. In the group, she could learn a new, more accepting attitude toward herself. A week after her first video and after seeing it, she says:

> ...It was exciting to see the video even though I remembered everything what I said... It would be nice to watch this video after ten years and see how I reacted... And how my life is then...

Discussion

Although the WDP was designed with both therapeutic and research aims in mind, the overall objective was to provide a space in which depressed women were able to talk about their depression in their own words. While there has been an increasing amount of description of depression from the lay perspective (Lewis ,1995; Tontti, 2000; Kangas, 1999, 2001), there is a paucity of qualitative research about practical psychiatric work, both evaluative and developmental, in this field (Isohanni, 1998) carried out by a treater.

On a therapeutic level, video recording presented an opportunity for both client and therapist to evaluate work that goes on in therapy sessions. It provided a therapeutic tool for future use. The therapeutic purpose was to help women to see and evaluate their current situations in terms of problems, life dilemmas, treatments they had experienced and ideas about their future. Here, the assumption was that when a group member watched herself being interviewed on a video monitor, it helped her to "see herself as others saw her," providing a mirroring effect. On this therapeutic level, the first author is an inside participant in the mental health field as a therapist of these patients. Through this "insider approach", the researcher belongs to the field by her occupation and is able to record her own impressions of being a part of the action (Maione & Chenail, 2001).

Video recording as a research tool provided a mechanism for feedback on experiences of depression "in members' own words." It also provided a temporal, visual embodied context in which a group member along with the group leader/therapist could chart her passage through her depression experience and WDP group processes.

In a real sense, the video interview was a visual narrative of the therapeutic session as well as visual data on embodied experiences of depression. It allowed a member to focus on a longstanding problem that, in her view, had led to the path of her depression. As we have seen, troubles with a partner, work or studies, with oneself or worries about family member(s) were viewed as key depression-generating problems. On the one hand, a respondent's telling of these problems becomes an enactment of memory, pain and emotions. On the other hand, these problems become embedded in a visual, healing narrative upon which a member reflects.

It becomes clear that the video was not only used to collect data on "depression initiating" problems: it was also used as a technique to reveal to members that depression is a complex phenomenon. It is "experiences which arise in conjunction with one's embodied efforts to meet socially constructed standards defining a good woman" (Stoppard, 2000: 108). Thus, troubles with a partner, work or studies, with oneself or worries about family member/s, while viewed as key problems by members, were not the only source of their depression. Rather, their depression is the outcome of processes of shared interactions between one's physical embodiment and one's constructed experiences. In this sense, the video becomes one important way for members to visualise this interaction and to build upon their own healing narratives. Researchers have argued that without visual identity there is no presence, and that this means no social support networks and no community (Ainley, 1995, cited in Holliday, 2000: 122). Whether or not the women of the WDP found a strong sense of community through video interviews, they could at least come to a sense of their own visual identity which gave them potential for community participation. As Denzin (1995: 1) has said:

> ...the postmodern is a visual cinematic age; it knows itself in part through the reflections that flow from the camera's eye. The voyeur is the iconic postmodern self. Adrift in a sea of symbols, we find ourselves voyeurs, all products of cinematic gaze.

While depressed women in this study are a part of this cinematic gaze, through video interviews they have at least experienced their own visual identity, which is a product of the problems which form in their depressive

experiences. Hopefully, the findings in this paper have mapped out areas for further exploration about using video interviews as both a research and therapeutic tool with depressed women.

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THE ROLE OF COMMUNITY-BASED GROUPS IN THE PREVENTION AND RECOVERY OF POSTNATAL DEPRESSION

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The aim of this research was to examine the role of group membership with regard to positive mental health outcomes for women with young children. Specifically, the research was designed to explore whether community-based groups provide aspects of prevention and health promotion in supporting otherwise isolated stay-at-home mums with young children. The groups included in the research were based on a model of operation which aims to increase social connectedness, provide peer support for parenting, increase well-being, reduce the risk of postnatal depression and other mental illness, increase self-esteem, and develop community. The research employed a questionnaire-based survey of three groups of women, those who participated in a community-based women's group, women who participated in one of a number of ACT playgroups, and stay-at-home mums who were not participating in a parenting-related community group at the time of the research. Analysis compared each of the research groups on measures of social connectedness, group belonging and support, resilience and postnatal depression. Results are discussed in terms of the value of community-based parenting groups in health promotion, prevention and recovery of postnatal depression.

Introduction

Previous research has identified the need for community programs targeting women with young children (Box, 2005). It has been suggested that women are more likely to experience mental health problems during the postpartum period than at any other time in their lives, and social isolation is common for mothers who choose to stay at home (NHMRC, 2000). Many health programs and studies have established and examined parenting groups facilitated by nursing or other health professionals;

however, there has been growing support for community-based parenting groups where parents are empowered to play an active role in the development and management of the group (Tomison & Wise, 1999; Prilleltensky & Nelson, 2000). Fostering a sense of community is thought to have important health benefits (Smith, Baugh-Littlejohns & Thompson, 2001), and community-based parenting groups have been found to improve parenting skills and self-esteem (Zeedyk, Werritty & Riach, 2003), and enhance social support networks (Prilleltensky & Nelson, 2000) and thus resilience.

Many women at home with young children feel profoundly isolated as they face the challenges of the parenting role and adjust to it. For women, the postnatal period is a time of particular vulnerability to mood disorders which carry significant risks, not only for the women concerned but also for their children and partners. The importance of infant attachment, early positive parenting and the family and social environment during the first three years of development is well documented (Milgrom, Martin & Negri, 1999). These foundations of a child's cognitive and emotional development can be jeopardised by maternal mental health problems such as postnatal depression.

Studies have consistently shown that between 10 and 20 percent of Australian women experience postnatal depression and a further 35 percent experience some form of distress or anxiety during the first year of their baby's life (Najman, Andersen, Bor, O'Callaghan, & Williams, 2000). Based on the high incidence of mental health problems in mothers, there is a need for interventions that target this high-risk group in an attempt to prevent or reduce the known risk factors.

This report provides preliminary findings of the evaluation of the Majura (MWG) and Brindabella (BWG) Women's Groups with respect to social inclusion, community development and mental health promotion. The MWG and BWG were established for mothers at home who are the primary carers of infants and young children in an attempt to decrease their vulnerability to mental health problems. The Groups aim to increase some of the protective factors for both mothers and children using a creative and economical approach enhancing community networks.

The project involved collection of data from women participating in the MWG and BWG. For comparison purposes, data were also collected from women participating in one of a number of ACT playgroups and also from stay-at-home mums who were not currently members of a parenting-related community group. By comparing data from the MWG/BWG to those from women who attend playgroups and women who are not