



Introduction

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DEPRESSION HAS BEEN IDENTIFIED worldwide as a mental health problem that occurs with alarming frequency.¹ It is the most commonly encountered mental health problem among women and ranks overall as one of the most important women's health problems.² One recent, large-scale study, for instance, reported that more than one out of every five American women will become depressed at some time during her lifetime.³ The comparable figure for American men was around one in eight. Indeed, studies conducted in many countries generally have found that almost twice as many women as men become depressed.⁴ This pattern occurs in research samples of people living in the community, those visiting their family doctor, and those receiving treatment in hospitals. Not surprisingly, women also predominate among those receiving antidepressant medications.⁵

Although researchers have studied depression extensively in recent decades, women's depression has rarely been the primary focus.⁶ And when the topic has been addressed, the perspective represented has typically been that of researchers, rather than the views of depressed women. We know very little, therefore, about the experiences of women who have been depressed.⁷ This book addresses this knowledge gap by bringing

together work on women's depression from the standpoint of women, grounded in women's own stories about being depressed.

What Is Depression?

I was really depressed and . . . I did have suicidal thoughts and I had my suicide all planned out, too. . . . I did not want to get out of bed in the mornings. I just wanted to stay in bed and sleep.⁸

With depression it is total dysfunctioning. . . . I feel like there is this child inside me just crying, crying, crying, and I am the shell on the outside trying to be this different person.⁹

I had no energy, my mood swings were getting to be more frequent. . . . You feel as if you are in this black hole and there's no light. You cannot see a light at the end of that tunnel.¹⁰

I think it's a mental and physical breakdown . . . of everything. . . . You can't think straight, or you can't think to cook dinner for your kid, or you're going to be in bed all day. . . . You don't want to do anything.¹¹

These are brief extracts from interviews with women about their experience with depression. Most people are familiar with feeling sad, down, or low, especially after experiencing a personal setback, disappointment, or loss. Although feeling sad is part of being depressed, depression involves more than a low mood. As the brief excerpts above illustrate, lack of energy, tiredness, and inability to engage in everyday activities are also aspects of depression. A depressed woman is also likely to lose interest in activities she would usually enjoy, to have difficulty thinking and concentrating, and to have low self-esteem. Her thoughts may be colored by feelings of hopelessness about her current situation and future possibilities. Such negative thoughts may lead a woman to conclude that life is not worth living and to contemplate suicide. But, being depressed does not only involve negative thoughts and feelings. A woman may also experience physical changes; in particular, she may eat less (or more) than usual and her sleep patterns may be disturbed.

In textbooks written by experts, "depression" is defined as a mental illness, a disorder caused by a biochemical imbalance in the brain. Unlike

physical diseases, most mental illnesses, including depression, are identified primarily by the symptoms a person reports. There are no tests comparable to blood tests or x-rays that can determine whether or not a person is depressed. A health professional, such as a physician, asks a patient to describe her experiences, and what she reports is then evaluated against a set of symptoms, or diagnostic criteria, for depression.¹² These criteria operate as a standard template against which a particular person's experiences can be compared. For example, in the first excerpt above, a woman describes herself as having suicidal thoughts, having trouble getting out of bed, and wanting to sleep all the time. These experiences map onto several symptoms of depression—thoughts of ending one's life, reduced energy, and decreased activity, along with increased sleep. If this woman told her doctor that she had been experiencing these symptoms for two weeks or more, as well as feeling depressed and apathetic, she would probably be diagnosed as having a depressive disorder and be treated with an antidepressant medication.

When a depressed woman seeks medical attention and is diagnosed with depression, her depressive experiences are legitimized as symptoms of an illness and given a medical label. In this diagnostic process, a woman's experiences are validated—"there really is something wrong with me," "it is not just in my head," "I'm not going crazy." Her feelings of distress and ill health are not her fault, she is not to blame—she has an illness called depression, which involves a chemical imbalance in her brain. When personal blame for being depressed is removed, a woman can attribute her distress to something outside her control—her brain chemistry. This way of understanding depression implies that a depressed woman has a physical disorder, the remedy for which is a drug. However, this view of depression can also go hand-in-hand with the idea that one is flawed in some way or otherwise weak. And there is still stigma attached to being diagnosed with a mental disorder, even if it is understood to be biochemical in nature.¹³

In the diagnostic process, health professionals abstract limited aspects of a patient's experience from her ongoing life circumstances and label them as "symptoms." Shorn of their individual details, depressed people's experiences are assumed to have common symptomatic features that can be identified in anyone who is depressed. Once diagnosed as depressed and a treatment prescribed, a woman's experiences are likely to be of interest

only for evaluating whether treatment is helping to alleviate her depressive symptoms. Likewise, in much research, depressed women's experiences serve primarily as a starting point for generating scores on questionnaires or surveys, which researchers transform into numerical data and statistics.

Recontextualizing Women's Depression: Qualitative Inquiry

In conventional approaches to research and diagnosis, information about a depressed person's life circumstances and everyday activities is stripped away as unnecessary detail in a process that "decontextualizes" people's experiences. When these details are retained, however, they cast new light on experiences that might be counted as instances of depression by researchers or labeled as depressive symptoms by health professionals. Recontextualizing depression enables researchers or therapists to see depression not just as an individual pathology requiring individual change, but as embedded in relationships and social settings. A qualitative approach highlights the context of people's experiences by paying special attention to the details of their lives. The advantages of this strategy can be illustrated when we add some contextual information to the first excerpt presented at the beginning of the previous section.¹⁴ The woman whose interview was the source of this excerpt was married and had a school-aged child. She talked about becoming depressed when her husband's business failed and the family faced bankruptcy.

Well, there was nothing we could do about it, I mean, we had no money. . . .
And of course in this society, when you make debt, you want to pay it. That is the responsible thing to do and so here you owe all this money and there is nothing you can do about it.

Earlier in her interview, she had spoken about an incident that occurred when she was a student, drawing a link between this event and later becoming depressed.

But to me the real pivotal thing was I was raped by one of the guys at university I used to have coffee with. He invited me over to his apartment . . . date rape type of thing . . . but it took me ten years to admit that I was raped.

Some contextual detail can also be added to the second excerpt in the previous section.¹⁵ The woman interviewed was married and had a daughter. She also had a full-time job. In the following excerpt she describes what a typical day is like for her.

I work Monday to Friday, I get up in the morning, I get ready, I get my daughter ready, we are off to work. My lunch hours are spent running around the malls to pay bills or to pick up this or whatever, I am back to work, I get home, I cook supper, I do homework, and then there is the bath, then there is quality time of playing, and she [her daughter] is off to bed, then I'm in the bedroom ironing . . . and the next thing you have to go to bed because I have to get up early again the next morning and start all over again.

This woman took care of elderly relatives in addition to looking after her own family:

And now my husband . . . his aunt, she has got Parkinson's and she is suffering from depression herself, so she is having a hard time coping, so I am paying her bills and I am doing her laundry, and I am doing his father's laundry.

As we hope these examples show, new ways of understanding these two women's experience of being depressed begin to emerge when information about their lives is introduced. Their stories are enlivened when their own words are used, and their accounts also point to the importance of context for understanding women's depression. While conventional research seeks general patterns by stripping away social context, qualitative research attends to the details of people's lives.

The authors of the following chapters chose to use qualitative methods in their research on women's depression, approaches that seldom have been used to study depression.¹⁶ Qualitative research contributes knowledge about the meaning of depression in women's lives and also enables a deeper understanding of the situations in which women become depressed by opening up questions about power, about ideologies and practices of gender, and about other social, structural inequities in women's lives. Understanding a woman's experience from her own point of view also has

practical value because it has the potential to open up other—possibly more fruitful—avenues for intervention (in therapy and community-based programs) and change.

Situations That Increase Women's Risk of Becoming Depressed

Research using a broad-brush approach has pointed to certain types of situations that are associated with an increased risk for women of becoming depressed. These are characterized by social inequality and poverty—conditions in which women are notoriously over-represented.¹⁷ At all stages of life, women also face an increased risk of being sexually or physically abused—forms of trauma that have been linked to women's depression.¹⁸ Situations arising from women's reproductive capacities, particularly child-bearing and child-care, also can heighten the risk of depression for women.¹⁹

Some of the chapters in this book focus on women living in situations associated with an increased risk of becoming depressed. For instance, Yvette Scattolon interviewed low-income women living in rural communities in eastern Canada. Vivienne Walters, Joyce Avotri, and Nickie Charles talked to women living in low-income areas in Wales, in the United Kingdom, and to women living in the West African country of Ghana, where poverty is an endemic feature of women's lives. Women's experience of becoming a mother is the topic of Natasha Mauthner and Paula Nicolson's chapters.

Qualitative research also makes possible a more fine-grained exploration of people's experience, the way they interpret events in their lives, and the impact this understanding has on how they see themselves. Some qualitative researchers are particularly interested in the meaning embedded in people's talk. Meaning is reflected in the literal content of people's words, and also is conveyed metaphorically. Linda McMullen shows in her chapter how paying close attention to the way women talk about being depressed reveals new insights about the meaning of depression in their lives.

Talking about being depressed involves describing and making sense of subjective experience, a process in which a person draws on ideas, views, and opinions gleaned from family, friends, or professionals, and increasingly from the mass media. These understandings are likely to incorporate

the prevailing stories or narratives about depression—its nature, causes, and cure—that have gained credence within a particular social context. In Western societies, the dominant narrative is one that privileges a medicalized view of depression as an illness involving a biochemical disturbance in a person’s brain. Janet Stoppard and Deanna Gammell focus on depressed women’s experiences of treatment—primarily antidepressant medication—to assess the implications of such treatment for a woman’s sense of self and how she lives her life. In contrast, Yvette Scattolon explores the experiences of women who did not seek professional help when depressed. Women who live in rural areas where mental health services are lacking are probably over-represented among those who contend with depression on their own, with no outside help. Yvette Scattolon analyzes how rural women coped with being depressed when their experience was not validated by a medical diagnosis.

Women’s feelings and actions in everyday situations and their ways of expressing emotional distress are also embedded in culturally shared meanings of what it means to be, act, and live as a woman—cultural narratives referred to as “discourses of femininity.”²⁰ Anger, for instance, is an emotion that sits uneasily with cultural conceptions of the “good woman.” In her chapter, Dana Jack charts the varied strategies women adopt to cope with angry feelings and maps the impact these strategies have on women’s experience of being depressed. Other authors also draw connections between the culturally authorized narratives of what constitutes appropriate womanly behavior and the social situations in which women become depressed. For instance, Susan Hurst describes how the experience of betrayal and abandonment in an important relationship is a common theme in the accounts of women who have been depressed. These women’s experiences arose from situations structured by cultural narratives that prescribe both relational and economic dependency for women.

Doing Qualitative Research

In qualitative research, people’s accounts are treated as a vital source of information about their subjective experiences and the circumstances of their lives. Many qualitative researchers collect information by talking to people, either individually or in small groups, about some aspect of their experience, and most contributors to this volume used interviews as their primary

data collection method. However, sometimes qualitative researchers may use material that has already been collected (e.g., archival databases) or that is publicly available, either in print (e.g., books, newspapers, magazines) or as recordings (e.g., movies, videos, CDs). Another, more “anthropological” method involves a researcher becoming a participant-observer in a social setting or organization relevant to her research question. In summary, qualitative research encompasses diverse methods for collecting data.

Analysis of qualitative data usually focuses on text—sometimes a researcher’s notes or, more often, verbatim transcriptions of audiotaped conversations. Various strategies for analysis of qualitative data are represented in the chapters that follow. Several chapters—for example, those by Paula Nicolson, Janet Stoppard and Deanna Gammell, and Vivienne Walters, Joyce Avotri, and Nickie Charles—draw on thematic approaches, with the goal of identifying patterns of meaning within the content of interviewees’ responses.²¹ The “grounded theory” method used by Susan Hurst also involves a thematic form of analysis, in this case the aim being to reveal the social processes that best account for participants’ experiences.²² Dana Jack and Natasha Mauthner describe the analytic returns from a “voice-centered” approach, a strategy that involves reading and rereading interview transcripts from various points of view.²³ The analytic focus in Linda McMullen and Yvette Scattolon’s chapters shifts to how women talk about their experience, the former from a linguistic perspective and the latter from a discursive standpoint.²⁴

These various analytic approaches entail differing levels of analysis, which allow researchers to “hear” different things depending on the strategy they use.²⁵ In some, people’s social situations are of particular interest—what is happening in their lives? The focus of others is people’s subjective experience—what are they feeling and thinking? Thematic approaches are often used to shed light on the nature of people’s everyday lives, as Vivienne Walters, Joyce Avotri, and Nickie Charles show in their chapter. Researchers might also use thematic analysis to study how people experience specific events or circumstances in their lives. For instance, Paula Nicolson was interested in women’s experience of becoming a mother, and Janet Stoppard and Deanna Gammell explored the ways in which women experienced their treatment for depression.

Other types of qualitative analysis are “inductive”—researchers attempt to let the data “speak for themselves” without imposing a theoretical perspective. The grounded theory approach Susan Hurst employed exemplifies a form of inductive analysis in which women’s accounts are used as a springboard for devising a theory that best describes their experience. Voice-centered methods, in contrast, are based on assumptions about subjectivity—people’s subjective experience and how they see themselves. Researchers such as Dana Jack and Natasha Mauthner use a voice-centered approach to explore the links between a person’s social location and her subjectivity, how cultural narratives shape a woman’s sense of who she is, and how she attempts to resist cultural definitions and stereotypes. Voice-centered strategies trace the impact on subjectivity of power dimensions—gender, race, and social class are examples—within interpersonal relationships and through broader societal dynamics that govern access to important social resources such as money and status.

Yet other analytic strategies examine how people talk about their experience by attending to the meaning evoked by the particular words used. Linda McMullen, for instance, deploys a linguistic method of analysis to highlight how women convey their experience through use of metaphors, idioms, and figures of speech. Linguistic analysis helps us to hear more clearly the evaluative undertones in people’s words—how language shapes subjectivity and channels their experience of the world. Language is also the subject of discursive modes of analysis, but at a more “macro” level than linguistic approaches. From a discursive perspective, language is not only a way to communicate experience, it is also a form of social action that embodies meaning. For instance, when a person talks about her experience, inevitably she will draw on some narratives—or stories—within her culture, rather than others. The type of narrative a person uses reveals something about the social and cultural context of her life and the dynamics of power that give authority to certain narratives but not others. The cultural narratives embedded in people’s talk about their experience function discursively to circumscribe the “positions,” or roles, a person can take in her own life story so that certain actions—or social practices—seem proper while others are ruled out or denied, as Yvette Scattolon shows in her chapter. Although linguistic and discursive modes of analysis differ in their analytic focus, both are designed theoretically to enable researchers

to connect the personal, psychological experience of an individual—one woman’s story—to broader structures and social relations. These analytic approaches help to reveal how a larger set of social forces organizes the way we experience, speak about, interpret, and live our lives.

Like all researchers, those who use qualitative methods must address ethical issues in their work.²⁶ Because the data in qualitative research usually consist of verbatim accounts of people’s experience, often on sensitive or personally significant topics, researchers take special care to preserve the confidentiality of their sources. This is accomplished by using pseudonyms to shield the identity of participants and by masking details that might be recognized by others. Researchers also strive to disclose to participants as fully as possible why they are doing the research and how the qualitative information they collect will be used. In situations already bound by confidentiality requirements, such as conversations between a doctor and a patient or between a therapist and a client, researchers must take pains to ensure that those in less powerful positions (i.e., patients and clients) are able to consent freely to becoming research participants.

Beyond concerns for anonymity, confidentiality, and informed consent, qualitative research brings ethical dilemmas into view that may be less visible—but no less present—in conventional research approaches. These issues are embedded in the relational character of qualitative research and arise from the inherently interpretive nature of qualitative analysis. Some of the questions that researchers must grapple with include “who owns the data?” “whose interpretation of the data carries the most weight?” “who benefits from the research?” and “when do researchers’ obligations to participants end?” Qualitative researchers directly confront the political dimensions of their work when deciding to pursue a particular research goal. For instance, if the goal is to better understand women’s depression, should we turn to the writings of experts or should we talk to women who have been depressed? Whichever route we choose will lead to somewhat different answers because the people involved (experts versus depressed women) have different experiences and perspectives.

All of the authors included in this collection chose to ground their research in women’s experience. Their essays also address questions of “difference” among women by working through intersections of gender, race, ethnicity, class, living arrangements, and geography. The new ways of understanding women’s depression presented here not only challenge the

views of experts—they also have implications for the kind of health and social policies needed to address the problem of women’s depression. At the same time, we should acknowledge that the interpretations of depressed women’s experience presented in the chapters that follow are themselves shaped by the researchers’ world views. In this respect, the interpretations offered are “partial”—others might interpret the women’s accounts differently—a caveat that applies equally to the findings of research using conventional approaches.

Qualitative researchers also need to consider the impact of their research on those who participate. For the women whose stories are told in this book, was their experience as a research participant helpful or harmful? From our perspective as researchers, we find that women are usually quite willing to share their stories about being depressed, often describing the process as “therapeutic.” Women also express the hope that their stories will be helpful to other women who are depressed. One way for researchers to ensure that the stories research participants share with them can have an impact in the world is to make their work available to audiences beyond other researchers. This book provides a means to make accessible to a wider audience the fruits of qualitative studies on women’s depression.

Aims of This Book

The central purpose of this book is to highlight the contributions of qualitative research to understanding what being depressed is like for women, the situations in which women become depressed, and what women do to overcome being depressed. Therefore, this book does not address women’s depression from a medical or psychiatric perspective. Nor is it intended as a “self-help” guide for depressed women, though some of the experiences described herein may resonate with those readers who are or have been depressed. We hope that therapists and counselors will gain insight into the experiences of depressed women from reading this book, and some authors (particularly Linda McMullen and Susan Hurst) address the implications of their findings for therapy with women.

Our primary aim in collecting these studies is to show how use of qualitative approaches can open up new avenues for answering the questions “Why do women become depressed?” and “Why is depression a problem

that particularly afflicts women?” Qualitative studies can also point to questions that deserve more attention, a critical one being “When do women become depressed?” The situated nature of women’s depression is repeatedly documented in the following chapters. It is our hope that this collection will encourage and stimulate others to pursue studies of women’s depression using qualitative approaches.

Notes

1. See World Health Organization, *The World Health Report 2001: Mental health: New understanding, new hope*.
2. See World Health Organization, *Women’s mental health: An evidence-based review*.
3. R.C. Kessler, K.A. McGonagle, S. Zhao, C.B. Nelson, M. Hughes, S. Eshleman, H.U. Wittchen, and K.S. Kendler, “Lifetime and 12 month prevalence of DSM-III-R psychiatric disorders in the United States.”
4. M.M. Weissman, R. Bland, G.J. Canino, et al., “Cross-national epidemiology of major depression and bipolar disorder.”
5. J.A. Hamilton and M.F. Jensvold, “Sex and gender as critical variables in feminist psychopharmacology research and pharmacology”; World Health Organization, *Gender and the use of medications: A systematic review*.
6. Notable exceptions are G.W. Brown and T.O. Harris, *Social origins of depression: A study of psychiatric disorder in women*; D.C. Jack, *Silencing the self: Women and depression*; and the World Health Organization report, *Women’s mental health: An evidence-based review*.
7. See J.M. Stoppard, *Understanding depression: Feminist social constructionist approaches*, for an overview of research on women’s depression.
8. This quote is taken from J.M. Stoppard, A.M. Guptill, and M.N. Lafrance, “Understanding depression from the standpoint of women: Beyond medicalizing and pathologizing discourses.”
9. Ibid.
10. This quote is taken from the interview with a participant in the study reported by J.M. Stoppard and D.J. Gammell; see chapter in this volume.
11. This quote is taken from the interview with a participant in the study reported by Y. Scattolon; see chapter in this volume.
12. See American Psychiatric Association, *Diagnostic and statistical manual of mental disorders*, Fourth edition, p. 327, for a listing of diagnostic criteria for depressive disorder.
13. See J.M. Stoppard, “Women’s bodies, women’s lives and depression: Towards a reconciliation of material and discursive accounts,” pp. 17–18.

14. Contextual information is taken from J.M. Stoppard, A.M. Guptill, and M.N. Lafrance, “Understanding depression from the standpoint of women.”

15. Ibid.

16. An exception is autobiographical accounts by individuals who have been depressed. Interestingly, most such memoirs have been written by men. Examples of this genre are: N.S. Endler, *Holiday of darkness: A psychologist's personal journey out of his depression*; J. Bentley Mays, *In the jaws of the black dogs*; A. Solomon, *The noonday demon: An atlas of depression*; and W. Styron, *Darkness visible: A memoir of madness*.

17. World Health Organization, *Women's mental health: An evidence-based review*, pp. 15, 20.

18. Ibid., p. 65.

19. Ibid., p. 15.

20. See S. Bordo, *Unbearable weight: Feminism, western culture and the body*; J.M. Ussher, *Women's madness: Misogyny or mental illness?*; J.M. Stoppard, *Understanding depression*.

21. Further information on thematic approaches can be found in P. Banister, E. Burman, I. Parker, M. Taylor, and C. Tindall, *Qualitative methods in psychology: A research guide*, ch. 4, “Interviewing”; and R.E. Boyatzis, *Transforming qualitative information: Thematic analysis and code development*.

22. For descriptions of the grounded theory approach, see B.G. Glaser and A.L. Strauss, *The discovery of grounded theory: Strategies for qualitative research*; R.S. Schreiber and P.N. Stern, *Using grounded theory in nursing*; and A.L. Strauss and J. Corbin, *Basics of qualitative research: Grounded theory procedures and techniques*.

23. Information on voice-centered approaches can be found in L.M. Brown, “White working-class girls, femininities, and the paradox of resistance”; L.M. Brown and C. Gilligan, *Meeting at the crossroads: Women's psychology and girls' development*; and N. Mauthner and A. Doucet, “Reflections on a voice-centred relational method: Analysing maternal and domestic voices.”

24. For accounts of linguistic and discursive approaches in qualitative research, see J. Potter and M. Wetherell, *Discourse and social psychology: Beyond attitudes and behaviour*; C. Willig, *Introducing qualitative research in psychology: Adventures in theory and method*; and L.A. Wood and R.O. Kroger, *Doing discourse analysis: Methods for studying action in talk and text*.

25. For overviews of qualitative approaches used by researchers in psychology, see P. Banister, E. Burman, I. Parker, M. Taylor, and C. Tindall, *Qualitative methods in psychology: A research guide*; J.T.E. Richardson, *Handbook of qualitative research methods for psychology and the social sciences*; and D.L. Tolman and M. Brydon-Miller, *From subjects to subjectivities: A handbook of interpretive and participatory methods*.

26. See J. Marecek, M. Fine, and L. Kidder, "Working between two worlds: Qualitative methods and psychology," pp. 38–39, for a discussion of ethical issues in qualitative research.

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