WHAT'S LOVE GOT TO DO WITH IT?
THE RELATIONAL NATURE OF
DEPRESSIVE EXPERIENCES

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Summary

Clinical depression is a condition that involves depressed mood and intense sadness that lasts for more than a “normal” span of time. Depression has been considered a medical disorder by psychiatry and as such has been researched through “objective” positivist empirical methods. Very few in-depth qualitative studies on depression have been undertaken. This study looked at the depressive experience from a subjective perspective and found that depression is a complex process that involves relationships. Using methodical hermeneutical approach, (revised version of grounded theory), this study found that depression was largely a relational phenomenon. Under this category, three findings arose: self in relation, self-criticism and self-loathing, and loneliness and disconnection. Further conclusions suggest that the traditional medical “objective” conceptualization of depression is inadequate for understanding the totality of the depressed experience and that more emphasis should be placed on the “subjective” aspect of the condition.

Keywords: depression; relationships; grounded theory; qualitative method

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This qualitative research study was conducted to inquire into the nature of depression among young adults. Having gone through the experience of depression myself and having known many people who have been depressed, suicidal, and prescribed antidepressants, I decided to inquire about its recent reported proliferation among young adults (Canadian Mental Health Association [CMHA], 2004). Because I have been personally touched by depression, both in my own experience and by having lost people around me to its grip, I have had a vested interest in seeking out the process and possible outcomes of depression through this research.

I have also struggled with the epistemological and philosophical assumptions surrounding the scientific approach of psychology. This nagging criticism of the “objective” and “positivistic” method of understanding mental distress, or more specifically in this case depression, has followed me throughout the conceptualizing, carrying out, and writing of this research.

PHILOSOPHY OF PSYCHOLOGY AND DEPRESSION

I align myself with the philosophical thinkers in psychology who question the way we come to know the things we study. Although there is a small group of psychologists who subscribe to this approach, the mainstream academic disciplines, most particularly those who align themselves with the natural sciences, have tended to avoid these inquiries (Miller, 1992).

Through recognizing the importance of philosophy in approaching depression as my topic of inquiry, I entered into the fundamental philosophical problem of psychology: the metaphysical debate about the conflicting models of the nature of psychological reality. I came face to face with the philosophical issues currently being
discussed in psychology. “The key dichotomy is that of objective versus subjective: objective versus subjective reality, objective versus subjective knowledge, and objective versus subjective moral values” (Miller, 1992, p. 11; for more on the objective vs. subjective duality in psychology, see Kimble, 1984; Polanyi, 1955). These “key” issues became increasingly clear to me as fundamental cornerstones to my study of depression and my general dissatisfaction with the way this kind of mental distress is conceptualized in mainstream psychology. Miller (1992) describes objective as

philosophical positions that give priority to material or physical reality, to the kind of knowledge that can be gained of that physical substantial reality (i.e. clear cut measurements that are publically confirmable), and to absolute standards of right or wrong. (p. 11)

To apply the “objective” method to depression is to think about the way it is currently conceptualized in mainstream psychology: through the medical model approach that assumes that depression is a mental disease to be removed from the body as quickly and efficiently as possible. The use of manuals such as the Diagnostic and Statistical Manual of Mental Disorders that have a checklist of observable symptoms, the use of antidepressants, and the general consensus that depression is a biological malfunction are examples of this approach (American Psychiatric Association, 1994).

In contrast, Miller (1992) describes subjective as

philosophical approaches that give priority to mental reality (ideas, images, feelings, dreams, etc.); to knowledge claims that are the result of introspection, intuition, or insight (and, consequently, very personal, private, and not usually confirmable to other people); and a relativistic concept of moral truth and goodness. (p. 11)

To think about depression subjectively is to think about it experientially, as in qualitative inquiry, where the focus is on the personal narrative and context of the person experiencing the distress.

The subjective understanding of depression was explored in this study through the use of qualitative methodology. The research questions were: What is the subjective experience of being depressed among young adults? Can knowing about this experience teach us anything about the development and process of depression?
LITERATURE REVIEW

Canadian studies looking at lifetime incidence of major depression found that 8% of adults older than 18 have met the criteria for a diagnosis of major depression at some time in their lives (CMHA, 2002). In an even more recent report, two thirds of Canadians (67%) have reported having experienced depression or anxiety (CMHA, 2004). According to the 1994/1995 National Population Health Survey, 6% of the Canadian population aged 12 years and older had symptoms consistent with depression at the time of the survey (Health Canada, 2002). The CMHA (2002) states that more than 3,700 Canadians kill themselves each year, and 4% of Canadians attempt suicide in their lifetimes. Suicide accounts for 24% of all deaths among 15 to 24 year olds and 16% among 25 to 44 year olds. Even more significantly, a 1994 United Nations study during a 3-year period found that Canada’s suicide rate in children and youth is among the highest in the world (CMHA, 2002). Statistics Canada states that in 1996 alone, there were close to 5,200 attempted suicides for both males and females between the ages of 20 and 44. Depression is also a serious issue, with close to 500,000, or 27% of people between the ages of 18 and 34, reporting that they had been feeling depressed for an average of 5 to 6 weeks every year (CMHA, 2002). It should be noted that statistics on depression and suicide in Canada are higher in some areas than in others. For example, suicide rates among the aboriginal population are 3 to 6 times the rate of the national average, depending on the community (CMHA, 2002). Similarly, British Columbia, which has a large population of aboriginal people, shows higher rates of depression than do other provinces such as Ontario (CMHA, 2004). The high rates of depression and suicides among certain clusters of communities may skew the overall Canadian picture. Finally, depressive disorders appear to be emerging earlier in life, with the average age of onset now in the mid-20s (Health Canada, 2002; National Institute of Mental Health [NIMH], 2001).

METHOD

The grounded theory method (Glaser & Strauss, 1967) is seen by Rennie (2000) as a hermeneutic approach, described as methodical hermeneutics. Methodical hermeneutics is based on the attempt to
reconcile relativism and realism that involves an acknowledging of the researcher's horizon of understanding. A horizon of understanding includes the researcher's own implicit and explicit personal biases that evolve from cultural and historical contexts. The essential feature of this kind of grounded theory method is the development of categories that emerge out of texts that represent the experience of the participants. The aim is to let concepts, hypotheses, and themes develop during the research process through the constant interplay between data collection and analysis. Using the methodical hermeneutic approach, the researcher creates categories through the generation of new ideas or interpretations of the text. Categories usually begin descriptively and then move to “higher-order” categories, or more abstract ones that merge the descriptive ones in their breadth. The goal is to achieve a core category that gathers together the meanings of all the other categories. The researcher then goes through an inductive process whereby the original ideas are continually compared and contrasted to the textual evidence that is grounded in the data. Grounded theory analysts use their memos, their intimate knowledge of their data acquired through the interview and transcriptions, and their own experience to attempt to understand the experience of others as mediated through the text (Rennie, 2000). Through the process of induction, which involves rigorous and constant testing and revision of categories and subcategories, themes that emerge are internally validated because they come directly from the data and are under constant scrutiny for text-based evidentiary support.

PROCEDURE

Participants

Open-ended interviews were conducted with graduate students at York University who met the DSM-IV criteria for either current or past clinical depression. Graduate students were chosen because they tend to fit the age range (18-30) that is currently experiencing a reported increase in episodes of depression (Health Canada, 2002; NIMH, 2001) and because they were a convenient sample. The graduate students were recruited at two local universities in Toronto and assessed by Clinical Structured Interviews.
Diagnosis (SCID). The SCID is based on *DSM-IV* criteria and asks about a variety of mental disorders including affective, psychotic, anxiety, and personality disorders. None of the graduate students met criteria for *current* depression according to the SCID, but all of the participants had gone through an episode of clinical depression within the past year of their interviews and were referring to that episode when speaking about their experiences. A total of six interviews were conducted (five women and one man). Each participant was asked to sign an informed consent form and was given a pseudonym for confidentially purposes. All participants were between the ages of 25 and 30. Four were Canadian born, one was Asian, and the other was of Turkish descent.

**Interviews**

All interviews were conducted in an office in the Behavioral Sciences Building of York University. I began the interviews by introducing myself and explaining the purpose of the study. Once consent was obtained, both verbally and in writing, I began the interview. The interview had two parts. In the first section, I asked the participants to speak about their experiences of depression, including how it felt for them to be depressed, what they think caused their depression, what they were thinking and feeling at the time, and how they got out of it, if indeed they had. The second part of the interview had to do with questions of meaning and identity. These questions asked about the kinds of things they found meaningful in life and how these elements contributed to their understanding of themselves, others, and the world in general.

**Transcriptions**

I transcribed all the interviews myself immediately after the interviews. Transcriptions included all speech and all audible idiosyncrasies such as pauses, intonations, expressions, and silences. Incomprehensible expressions, words, or phrases were also recorded with the goal of reproducing the entire interview as text.

**Data Analysis**

Transcriptions were broken into initial meaning units, that is sections of the text that appear to carry a uniform meaning. Each
unit was then studied, and its interpreted meaning was represented by one or more categories. This meaning unit was then assigned to the category or categories that emerged out of the interviews and pertained to situations, people, and perspectives of the participants (Bogdan & Biklen, 1992; Kirby & Mckenna, 1989). The main categories were then interpreted to include subcategories that emerged most often out of the data to illuminate the major themes. Once all the data had been assigned to categories, the major themes stood out clearly through, first, the number of times a category came up and, second, through how many times categories combined with one another. Through the constant comparison of the categories method which involves comparing all the categories to each other (Glaser & Strauss, 1967) and through the inductive verification process (the inductive process involves rigorous and constant testing and revision of categories and subcategories), themes were tested for validity and usefulness as representing the phenomena under inquiry (Rennie, 2000; Rennie, Phillips, & Quartaro, 1988; Strauss & Corbin, 1994).

Memoing

Another procedure used was memoing. Memos, sometimes called analytic notes, are the researcher’s reflections about the process of the study. As soon as possible after each interview and through the process of coding and analysis, I wrote memos in which I described my impressions, thoughts, and feelings about what the participants were saying. These memos were then used to help analyze the data in two ways. First, they provided insight into what my “gut feelings” and impressions were of the participants (which served as interpretations to be tested against the textual evidence). Second, they helped me to examine my biases, assumptions, and projections onto the data that I will expand on in the next section.

Horizon of Understanding

As a person who had experienced depression, I became in this study a “vulnerable observer,” which is what Behar (1996) has called a person who studies emotional topics that have personal significance.
My fundamental bias that stems from my own personal experiences and from observing other people with affective distress is that depression is not always caused by a biological malfunction or by cognitive distortions. Another assumption worth explicating is that I believe that human beings are agents of their own experiences and are the best informants of their life circumstances. I believe that people have a consistent notion of a “self” and can thus reflect and accurately report on their experiences.

My approach began by deconstructing mainstream psychology and the assumptions surrounding depression. I believe that depression is not a discrete entity that follows a particular pattern of symptoms, diagnosis, and treatment. My framework, then, is discursive, critical, and social constructionist. It is a look at how depression is understood from the subjective experience of the person experiencing it.

FINDINGS

Participants described their experience of being depressed as a feeling of being lonely and isolated from others. They felt uncomfortable around people and were anxious and agitated in public, causing further withdrawal from others and more isolation. There was a strange paradox here as all participants talked about having a craving to connect and desire to be with other people while feeling unable to do so. Participants also described feeling confused and fragmented while they were depressed, an experience akin to feeling like one is lost in a foggy haze. The feeling was one of complete and utter chaos. Thus, Sarah described this experience as being “like a dark hole” where she remembered feeling “so utterly confused, and so lost sometimes . . . like this little tiny thing far far away . . . of floating in the universe in the cosmos” (2-174).

They also felt deep sadness and pain so intense that it became physical, taking on an embodied form. Participants such as Alice described feeling paralyzed by their emotions and talked about depression as being a difficult and helpless time. On this theme, she described experiencing depression as a knot, like something “stuck in your throat . . . and if you don’t [release it], it just . . . stays there, even if you forget about it . . . . It just resurfaces somewhere . . . like some wound in you”(6-87). Similarly, Eliza described her depression as a deep knot in the pit of her stomach.
It felt like a physical pain, even though nothing was physically wrong . . . every time you breathed in, you could feel it, and it was constantly with you . . . . It was just an overwhelming sense of sadness. (4-103)

Along with feeling confusion, disconnection, and great pain, participants reported feeling anxious and nervous. Anger toward others and cavernous self-loathing also occupied the minds of the participants suffering from depression.

DEPRESSION AS A RELATIONAL PHENOMENON

Participants in this study reported that they got depressed as a result of a breakup in a significant relationship. Participants always spoke of their experiences in terms of a relationship to another person, whether through loss, lack of connection, loneliness, inability to find social support, or lack of feedback and friendship with others.

Five of the participants attributed their depression to a break in a long-term romantic relationship, and one involved a break from her parents. When participants talked about the breakup, they spoke of the intense shock and pain of being rejected by the person they loved. For example, Jeff talked about his breakup with his wife as the most difficult and painful experience of his life, describing it as “the defining loss for me . . . losing her . . . . I was ripping a piece of myself out of me . . . . It was really painful” (1-248). Other participants talked about feeling like failures because of the breakups (Deena, 2-59) and feeling such intense pain that it became physical. Eliza talked about feeling “a physical pain, even through nothing was physically wrong, you know it just, it was just such an overwhelming loss. You know every time you breathed in, you could feel it, and it was constantly with you” (4-27).

Self In Relation, Loss, and Depression

When participants talked about their relational experiences and their connection to their depression, they did not refer only to misunderstandings between themselves and their significant others; their problems were not restricted to an inability to make meaningful connections because of their depressed mood or about feeling devalued. Rather, the break in relationship and the subse-
quent depression struck to their cores and shattered the sense of selfhood that they had previously assigned to themselves. These participants understood themselves and constructed their identities in relationship to this other person, a process that has been termed the “self in relation” (Kaplan, 1986).

Deena described it concisely: “I think my relationships definitively give me a sense of umm, sort of like a sense of self, because, they are really what I am” (2-169). Similarly, Maya remarked, “A large part of my identity comes from my social relationships that I have. And ahh, the networks that I sort of situate myself... who I am to a large extent is where I fit into that network” (5-278). Also, Jeff talked about his inability to understand himself without the reflection or gaze of the other. He said, “Self analysis has always been difficult for me. That would come through my relationships with other people... Understanding myself is mostly through my friends” (1-236).

Those defining themselves through a web of social networks, as the participants described above, which included romantic partners, family, and friends, experienced considerable distress when there was a disruption to these networks. This disruption was associated with a subjective experience of depression for the individual. Each participant went through a process of grieving and missing that other person and grieving that missing aspect of self.

To summarize, the “self in relation” theory of identity asserts that people define themselves in relationship with others and that when there is a break in one of these social connections, the loss may lead to depression. The loss is experienced both as a loss of other and of self. Participants in this study all perceived interpersonal relationships as central to their self-definition and reported getting depressed as a result of a breakup in a relationship that led to a reconceptualization of themselves.

Self-Loathing and Self-Criticism

There was kind of like a... I don’t know, a self-loathing... I would just... scream and cry, and I’d usually, the things I was screaming was, I hate myself, I hate myself. (Sarah, 3-58)

Self-criticism came up surprisingly often in connection with depression and relationships. Although the intuitive understanding of self-criticism would lead one to think that it is about a nega-
tive relationship with oneself, the participants in this study talked about self-criticism and self-loathing arising in themselves in response to an outside gaze.

Sarah, who is quoted above, described her childhood as one punctuated with intense criticism from her parents. Her later depressions through adolescence and early adulthood were subsequently rife with feelings of self-hatred. In addition to having “no confidence,” she talked about herself as having “an internal flaw, and being inherently unlikable” (3-30). These feelings of insecurity and self-described bouts of shyness become particularly prevalent and magnified in intensity while she was depressed.

I become even more withdrawn than I normally am, and it’s based on the insecurity, and it came up the unlikeablity thing again, that I’m not likable inherently so what’s the use of pretending that I am because eventually they are going to find out. (Sarah, 3-126)

Alice similarly described herself as being particularly self-critical while being depressed, especially in response to the unexpected breakup. “I just had to deal with myself . . . before this (the breakup), I never felt like this . . . this worthless” (6-59). Other participants, similarly talked about feeling “inadequate,” “useless,” “flawed,” “failures,” and inherently “bad” people while being depressed. Although the feelings of self-loathing and self-criticism in relationship to others are not part of the traditional definition of depression, the DSM-IV does include the feeling of worthlessness as a symptom. The limit of the DSM-IV definition however, which will be discussed at length in the discussion, is that it diagnoses symptoms outside of context, thereby failing to take into account the relational aspect of the self-criticism exhibited by participants in this study.

Karp (1996) describes self-hatred as one of the key components of depression, which arises in response to the social stigma of mental illness. Depressive feelings, in Karp’s view, “emanate from and then reflect back on a self that is . . . inadequate, improper, disliked, or damaged” (p. 48). The self-hatred that participants experienced in this study, however, was always in response to someone else’s criticism. In this light, an alternative, more relational explanation of self-criticism is that self-loathing is an understandable response in people who build their sense of identity in relationship to others. If one’s sense of self is built, understood, and reflected through the
gaze of another, it makes sense that negative feedback will elicit negative feelings about the self. Subsequently, depression, which in its inception is rife with bad feelings, will lead to more negative emotions about the self when it is paired with the trauma of a breakup. This process of relationships, depression, and self-loathing then becomes a circular prison for the depressed person often leading to social withdrawal and feelings of loneliness.

Disconnection, Loneliness, and Social Isolation

In his sociological study on identity and depression, Karp (1996) described depression as being “an illness of isolation, a dis-ease of disconnection” (p. 15). All of the participants in this study resonated with this assessment and described their experience of depression as one of alienation and disconnection while craving connection and human contact. They were unable to initiate or sustain relationships because of feelings of severe discomfort around people. They described a cycle of feeling lonely, often as a result of their breakups, and then feeling depressed about the loneliness, causing a self-fulfilling prophecy by further alienating and self-isolating themselves from others.

This social isolation was reflected in the report by Jeff, whose depression was initiated by difficulties in his marriage and who described his experience of social interaction while depressed: “Being around people was, was always a bad thing for me. I constantly felt the need to be alone . . . and I always felt like interacting with other people was difficult for me” (1-36). He continued on this topic, “Ya, that was confusing because I felt lonely but I didn’t feel like being around anyone at the same time” (1-77).

While depressed, Sarah described her experience as being one of total and complete alienation:

I alienated everyone I knew. So I pushed everyone, like all my friends away, and it’s not like they stopped trying to be my friends, it’s not like they stopped talking to me. I just had this mentality that I was so alone. I was so hopelessly alone; I was just at this place that no one could possibly help me at. (3-186)

Last, Maya further clarified this theme by illustrating how her disconnection from her social network while being depressed caused her tremendous feelings of loneliness.
I think when I feel disconnected is when I’m at my worst . . . so feeling disconnected from kind of any, from the immediate social network [as she was when she was depressed] leaves me feeling very much kind of adrift in the world. (5-234)

As illustrated throughout, it is clear that depression was intimately connected to interpersonal relationships and that significant loss in relationships often causes great feelings of sadness and loneliness. As Karp (1996) points out, depression always has to do with “questions of isolation, withdrawal and lack of connection” (p. 26).

DISCUSSION

So what does love have to do with it? When asking this question in the context of depression, it seems the answer is “a lot.” Although not all experiences of depression are associated with relational experiences, and although no study can generalize to make conclusions about everyone, participants in this study explained their depressed experience always in a relational context. All the participants described their experiences in dialogue with, as a result of, and in the context of broken relationships. Subsequently, all of the participants were consistent in refraining from self-pathologizing.

One of the most important implications that came out of this research is the split between the traditional, objective view of depression and the actual lived experience of it. In the introduction, I mentioned that one the frameworks of this study was to situ ate the findings within the paradigm of objective science (that emphasizes physical reality and the ability to measure it) versus subjective understanding of depression (that prizes internal mental reality as a way of knowing). To reiterate briefly, the objective, positivist stance values the scientific approach. When applied to depression, it can be characterized by the medical model mentality that considers depression to be a disease that is situated within the individual outside of their social context; this model is the dominant one in psychological discourse. The subjective approach, on the other hand, focuses on the narrative of internal experience and emphasizes the context of the agents in understanding their behavior. To apply the subjective approach to depression is to take an epistemological stance that values personal narrative, as in this
research, and to consider depression at face value as an inherently valuable human experience, or in way that is nonpathologizing.

There were many findings that came out of this study that were explicitly engaged in this objective-subjective duality; many of them had to do with issues surrounding the definition of depression. An example of this emerged with the finding on anger and its relationship to depression. Anger, which is not part of the DSM-IV definition, was a very large part of participants’ experiences of depression. When participants talked about anger, their “targets” seemed to be very mixed; anger at another, anger in general, and anger at oneself were all intertwined and hard to separate. Why then, if anger plays such a prominent role in this sample, is it left out of DSM-IV criteria and thus by extension is left out of the dominant discourse on the nature of depression? One reason could be that it was merely a coincidence that anger appeared so pervasively in this study. It is always hazardous to generalize from a limited number of participants. On the other hand, the neglect fails to explain why anger is highly relevant in most narratives of depression and given a significant role in Freudian theory of depression (see Freud’s, 1917/1989, seminal essay “Mourning and Melancholia,” where he proposes that anger and depression are inseparable). Current psychological literature that has psychoanalytic roots has proposed that anger turned inward is a major symptom (or cause) of depression. This is illustrated through the intense self-criticism and low self-esteem as described by the DSM; yet, as Jack (2003) notes, depressed people often report feeling outwardly angry and hostile as well as inwardly dejected. Another explanation for anger being left out of the DSM-IV definition is that it implies that there is someone else involved in the depression. Anger is an emotion that is usually outwardly directed. Greenberg, Rice, & Elliot (1993), a process experiential clinician, has argued that anger is an “outward” emotion; when experiencing and acknowledging anger, people tend to come out of themselves and to direct the anger toward something or someone external to them. Guilt and depression, on the other hand, are inwardly directed or “shutting down” feelings (Greenberg et al., 1993). Meanwhile, Jack (2003) has written about the relationship between anger and depression. She states,

Both depression and anger share disconnection at their core. The experience of depression is one of profound separation, from others
and from oneself. Likewise, situations that arouse anger and aggression—injustice, inequality, and violation—create harmful rifts within relationships. Both anger and depression are also interpersonal, arising out of relationships and profoundly affecting relationships. (p. 76)

Including anger, therefore, would necessitate taking into consideration an outside variable that is part of the development of depression, which is counter to the “discrete entity” philosophy of depression as ascribed to by the medical model and the DSM. To view something as a discrete entity means to view it in isolation, outside of context. Because anger is a relational feeling in that it is directed toward someone or something, it cannot be part of a definition that considers only the individual in its scope. Feelings such as sadness, worthlessness, and guilt, on the other hand (the three feelings that are sanctioned by the DSM-IV as criteria for depression), are all personal feelings that are directed inward; they do not involve or assume any interpersonal qualities.

Another example had to do with self-criticism discussed earlier. Although feelings of self-loathing and self-criticism in relationship to others are not part of the traditional definition of depression, the DSM does allow for the feeling of worthlessness. The limit of the DSM-IV definition, however, is that it diagnoses symptoms outside of context, thereby failing to take into account the root of the emotion, which was the relational aspect of self-criticism exhibited by participants in this study. As opposed to being an individual fault as with the notion of internalized anger (Freud, 1917/1989) or with the theory of a self-critical personality (Blatt, 1974), self-loathing in this case was always in response to someone else’s criticism. In this light, an alterative, more relational explanation of self-criticism is that self-loathing is an understandable response in people who build their sense of identity in relationship to others who are critical of them.

These are just two examples of many specific findings that challenge the traditional medical view of depression. The overarching implication, however, houses all of these findings and has to do with the way depression is conceptualized and subsequently understood by the person experiencing it.

Although the medical model approach to depression emphasizes psychological treatment or the use of antidepressants to treat the pathology in the individual, the narrative perspective focuses on the subjectivity and subsequent context attributed to
the depressed experience. Because participants understood their depressed experiences in the context of broken relationships, they were consistent in refraining from self-pathologizing. In fact, 4 out of the 6 participants (all of whom clearly met criteria for clinical depression) did not get any professional help at all and were able eventually to come out of their depressions on their own.

To contextualize properly the findings of this study on the subjective experience of depression and the subsequent outcome for people who do not seek treatment, it would be necessary to explore other accounts of nontreatment studies on depression. This would be an oxymoronic endeavor, however, in terms of conventional research practice. Very few studies aim simply to observe the process of a psychological condition. The goal of modern psychological research is to test the efficacy of treatments for various mental disorders, thus resulting in very little research on “no-treatment” outcomes for conditions such as depression. As already indicated, most treatment of depression involves either psychotherapy and/or some sort of biological treatment with antidepressants. In fact, after conducting a comprehensive search of the psychological literature, I found only one study that observed depressed women who received no professional help.

Scattolon (2003) conducted a grounded theory study looking at women in rural areas who received no professional help for their depressions and found similar findings as this study.

Women tended to interpret their depressed feelings as “normal” and understandable, and therefore, as acceptable reactions to stressors that were external to themselves . . . . By “normalizing” their experiences, the women painted a picture of themselves as managing their depressed feelings in an appropriate manner, and as coping as effectively as they could under the circumstances. The women didn’t view their depressive experiences as in any way “pathological” or “abnormal” when considered in the context. (p. 179)

In addition to their “nonpathologizing” of their depressed experience, participants in Scattolon’s (2003) study resembled the experience of participants in this study in that they used nonmedical intervention–coping strategies. Participants in this study, therefore, were able to overcome their depression without psychological help or the use of antidepressants.

One of the most important implications that came out of this research is the split between the traditional objective view of
depression and the actual lived experience of it. Not only was there a profound gap between epistemological assumptions about the nature and etiology of depression between the objective and subjective views, but there were also some specific consequences that followed as a result.

Because participants viewed their depressed feelings as understandable within the context of their breakups, they “normalized” their experiences. In consequence, they did not perceive their depression as in any way “pathological” or abnormal and thus perceived themselves to be coping effectively with their problems.

I would like to conclude with two points. The first has to do with the actual findings of this study. Despite the popular view to the contrary, this study found that depression is largely a relational experience. As is evident from these findings, love has a lot to do with it. Participants not only got depressed because of breakups in relationships but were in constant dialogue (literally and metaphorically) with the people they loved as they went through their experiences. Relationships, therefore, were a continual presence in the lives of the depressed people.

The second point has to do with the implications of these findings. To think about depression relationally is contrary to the dominant medical view of depression that is currently popular. These findings challenge the view of “depression as disease” and implicate that there are alternative perspectives that are equally viable. Although it is beyond the scope of this article to discuss the consequences of viewing depression in differing frameworks, an essential point to remember is that different perspectives on depression lead to different consequences for people suffering from the condition. In addition, it is equally important to remember that the findings from this study came out of narrative and subjectivity. There is a lot to be gained by asking depressed persons to speak their stories.

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