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## **WOMEN ON THE WEB: A FEMINIST 'READING' OF DEPRESSION WEBSITES**

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### **Abstract**

*The focus of this paper is the use of a feminist interpretive approach, informed by material-discursive analyses to examine discourses on depression on Internet websites on depression. The paper will cover why this approach was taken, how it was implemented, our findings and the challenges that we faced.*

*A major strategy of the National Action Plan for Depression (Commonwealth Department of Health and Aged Care 2000) is the dissemination of health information aimed at the prevention of depression, and associated personal, social and economic costs. The experience of depression is highly gendered with women reporting higher rates than men (NSW Health 2002). The Internet is now a major source of health information, with one in three regular Internet users seeking on-line information about health and medical conditions (ACNielsen 2000). Within this wealth of web-based health information, depression now appears as a major topic of interest. This paper explores the construction of information being made available about depression on selected Australian web-sites, through a feminist 'reading' that identifies how gender figures in (or is absent from) explanations of depression.*

*Our interpretive practice is a critical reading of how websites circulate particular 'stories' about depression. We deconstruct the health information provided to women who access the Internet. Our interpretive practice draws upon material-discursive analyses of women's experiences of depression (Stoppard 2000, Ussher 1999). We focus on the discursive constructions of these sites, examining how ideas about depression connect with women's lives and emotions. We examine the gaps and silences that open up the possibility of other,*

*subjugated knowledges that are based on different assumptions about emotional health, illness and women's subjectivities.*

*In this project we positioned ourselves as Internet users, and critically engaged with the web-sites as 'texts', looking closely at each page as a text that constructed particular discourses about depression. In this reading we looked for 'how' meaning was produced 'what was said and not said'. We engaged reflexively to consider how these discourses spoke to us and about us as women – as feminine subjects who may or may not have identified as having depression when accessing the site.*

*This approach enabled us to analyse how particular discourses and narratives about women and depression are constructed. In this way it raises awareness of how women's knowledge of self, emotions and social life become 'subjugated knowledge' within the discursive terrain of biomedicine and therapy. With these insights however, come the challenges, and we acknowledge our engagement with these discourses from the position of being women ourselves, with inherent limitations of a white, middle class academic position. Yet, we also have a strength drawn from differences in age, sexuality and urban-rural histories. Challenges also come from the biomedical establishment, where expert knowledge is valued, and recognition is limited for any approach not based on certain kinds of evidence. We reply with the thought that we are challenging the nature of that evidence, questioning the inherent power relations in its production, relations that also shape all interpretive practice. In doing so we produce another voice that problematises the very practice of 'reading' health information and the web. This also creates a reflexive space for researchers to recognise the interpretive practices that constitute knowledge in particular (gendered) ways. A reflexive approach to interpretive practice brings increased awareness and transparency, with consideration and respect for a multiplicity of voices, ending in a reading which is itself open to other readings.*

## **Introduction**

Depression is the leading cause of the non-fatal burden of disease for women in Australia (Australian Institute of Health & Welfare 1999) with its highest incidence in the 18-24-year-old group (Commonwealth Department of Health & Aged Care 2000). As well as being a significant health issue depression is also an important economic issue. Treating depression is a major area of expenditure in health budgets. Prescriptions for antidepressants rose 60% from 1990 to 1998, going from 5.1 million to 8.2 million (McManus et al 2000), and continue to increase. Interpreting these figures is difficult. While they may represent a real increase in rates of depression, they may also represent an increased willingness to diagnose depression and/or an increased willingness to prescribe such medication. From the latter perspective, this is part of a broader and deeper socio-cultural shift in what is seen to constitute the experience and diagnosis of the phenomenon called depression. This expansion of depression as a category of mental illness is thus also a profoundly political issue that is being taken up within social, health and feminist debates (Fullagar & Gattuso 2002, Healy 1998, Stoppard 2000, Ussher 1991).

In 2000 the Australian National Action Plan for Depression was established with aims to disseminate health information and promote new ways of ameliorating the personal, social

and economic costs associated with depression. To achieve this end there has been a focus on increasing the populations' mental health literacy, which is broadly defined as the ability to recognise mental health problems and seek professional (i.e. medical) help (Jorm 2000). The powerful role of new media, such as the Internet, in disseminating mental health information has also been recognised alongside women's increasing use of the web for health related purposes as they juggle multiple time demands and responsibilities relating to work, leisure, family and health (Pandey, Hart & Tiwary, 2003). A number of specific Australian depression websites has also emerged with similar emphases (Christensen & Griffiths 2002, Christensen, Griffiths & Medway 2000).

Walkerline comments that the media is "the site of considerable importance in the production of subjectivity" (1997, p169). With an interest in how popular media texts mobilise meanings about depression for women we began a study of how women's magazines and popular websites represented depression. In this paper we focus on our reading of the depression websites, concluding with our reflections on interpretive uncertainties relating to the representation of women's 'voices' in our research. Our methodology is informed by a feminist, material-discursive analytic framework, in which we pursue a central aim of feminist research, "the ending of the invisibility and distortion of female experience" (Ussher 1999, p99). In using this approach we present feminist interpretive practice as inherently critical since "it centers and makes problematic women's diverse situations as well as the institutions that frame those situations" (Olesen 2003, p333).

### **Women, Depression and the Web**

Pandey, Hart & Tiwary (2003) argue that women are increasingly turning to the Internet as a source of health information for prevention and direct health needs, and that this is partly due to the time pressures associated with multiple gendered demands and responsibilities (as gatekeepers of family health). However, despite the fact that women are twice as likely to be diagnosed with depression as men, with an earlier age of onset and longer, often recurrent episodes (HealthyPlace.com, NSW Health 2002), there has been little attention paid to the relationship between gender and depression on Australian websites. There is a particular need to examine how websites are significant cultural sites in the representation of women's experience of emotional distress as depression.

Our focus on the discursive construction of depression on websites does not deny the serious and debilitating effects of that experience which may come to be diagnosed as depression on women's lives. However, we approach the issue of why women experience depression from another vantage point – one that emphasises how we, as a society, come to 'know' that certain emotional, embodied and profoundly social experiences are a mental illness, drawing on a rationalist scientific schema where experiences can be defined, classified and ordered. In doing so we draw upon a material-discursive approach that is also feminist in that it seeks to render visible the gendered nature of representations of depression for women. If we are to develop health promotion strategies and information that support women's emotional wellbeing and addresses the growing diagnosis of depression, then we need to examine how gender is positioned within current approaches.

We need, therefore, to examine health information on websites not only in terms of evidence-based 'quality', but also the gendered construction of depression as a personal, social or medical problem with attendant solutions (Lloyd & Hawe 2003). Such an analysis explores how 'depressive' identities and meanings are constructed and gendered in particular ways through health information that is generally presented as a neutral or helpful discourse. Drawing upon Foucault's (1980) discursive analysis we foreground the workings of power/knowledge relations as they produce the very language (metaphors, stories, symbolism) used to create meaning about women's emotional lives – their subjectivities. This is a very different approach to those studies that have evaluated the quality of health information on depression websites in relation to an evidenced base that privileges particular kinds of expert knowledge and standardised methods (Christensen & Griffiths 2002, Christensen, Griffiths & Medway 2000).

### **Using a Material-Discursive Approach**

Material-discursive analysis has been taken up by feminist researchers such as Ussher (1991) and Stoppard (2000). This interpretive practice explores the power-knowledge relations that produce particular truths about women's identity, the nature of depression and professional ideas about cause, treatment and prevention of mental health problems. The discursive domain of culture is not, however, divorced from the material, the lived, embodied aspects of everyday life. In relation to depression this involves understanding how women's lives are shaped by their experiences of violence, poverty, work, caring responsibilities, and so on that have embodied and emotional effects on the self. These are issues relating to the construction of women's subjectivity, that is, how women come to think and feel about themselves through the mediating work of culture and gendered relations with others. We are interested in the potential of a material-discursive analysis to facilitate transformations in the way we understand and produce knowledge about depression with respect to professional practices, policy directions and mental health promotion strategies.

We analysed selected websites from the position of being women ourselves who may be seeking information or support about depression. Acknowledging the limitations of our white, middle class academic position as women we drew strength from our gendered differences with respect to age, sexuality and rural/urban histories, when analysing the way websites mobilised particular discourses and narratives about depression. We considered what was said and, importantly, what was not said, the gaps and silences that point towards other, subjugated knowledges with different explanations about women's lives, bodies and subjectivities.

Our interpretive approach differs from hermeneutic traditions that presume meaning pre-exists language and resides within a subjective realm of experience. Rather, we develop a deconstructive 'reading' or critical engagement with depression websites as 'texts' that draw upon and produce particular discursive formations to explain cause, management and prevention. As critical readers we look closely at how each page mobilises particular discourses about depression (for example as a biomedical problem of chemical imbalance in the brain). In this way the practice of 'reading' texts emphasises 'how' meaning is produced in relation to 'what is said'. For example, do descriptions of depression draw upon

particular kinds of ‘expertise’ to legitimate their explanations of causality? We also think reflexively about how these discourses speak to, and about us, as women - as feminine subjects who have different knowledges of depression when accessing the site. Do these explanations of depression connect with our embodied and emotional experience of contemporary social life? What do they say and what do they not say?

### Searching the Web

Our initial web search was conducted from the perspective of an Australian woman Internet user wanting to access information about depression (and Australia), with no previous site recommendations or guidance. Thirteen of the most popular and well known search engines were used to search for “depression” and “depression and Australia”. The search engines used were Ask Jeeves, All The Web, Alta Vista, Google, Inktomi, Lycos, MSN Search, Teoma, Wisenut, Yahoo, Web Wombat, Look Smart, and Go Eureka. Eight of these search engines also offered a possibility to delimit the search by looking for sites from Australasia or Oceania, leading to an additional, limited search for “depression” within these sites only.

A total of 34 searches resulted, which all took place during the last week of February 2003. From each of these searches the top twenty sites were taken, all non-relevant sites were deleted (e.g. dealing with economic depression) leaving a total of 516 sites relevant to the subject in question. These sites were then ranked according to the number of times that they were found in these searches.

The four most easily found sites were identified as

**Table 1 : Most easily found depression websites**

Site Name	No of times found
Depression Site for Australians - your comprehensive depression resource (DepressioNet)	29
Depression.com.au	15
Beyondblue: the national depression initiative	12
Blue Pages depression information	11

This exercise showed that a tremendous amount of information about depression is available on the Internet, and a total of 155 different sources of information were identified. These sources were diverse, ranging from government agencies to specialist NGO’s, religious organisations to the media, individuals to pharmaceutical companies. This diversity illustrates how difficult it is for any one organisation or site to dominate a seemingly disorderly medium such as the Internet, where anyone can put up the information and content of their choice. From this observation it is tempting to assume that a wide range of information about depression is being made available, and that in this diversity a range of voices and emphases will be heard. Such assumptions are something we question as a result of our analysis in this project.

For the analysis in this project we added two more sites to those identified as the top four most easily found. The additions were Lifting the Fog (ranked 15 and chosen because it was a woman's personal webpage about her story of depression) and PaNDa (ranked 27 overall but included because of its specific relevance to women in dealing with ante-natal and post-natal depression). Therefore a total of six websites were used, with all analysis being done during April and May 2003. All site addresses are given in Appendix 1.

### **Discourses of Depression**

While all of the websites aimed to increase community awareness and mental health literacy about depression and its management, there were some key differences between their authorship and orientation.

- DepressioNet had clear 'consumer' involvement and focus
- Depression.com was a private psychiatrist's initiative with a user-pays system
- Bluepages originated from a University research centre in mental health
- Beyondblue stemmed from Australian mental health policy directions
- Lifting the Fog was an individual's story of her life and depression, and
- PaNDa is from an organisation supporting those with ante/post-natal depression.

Despite these distinctions, there were certain core themes that became apparent. The first of these was a voice of authority, and the manner in which the professional voice of psychiatry and clinical psychology was privileged. Another theme was the identification of depression as an illness, with the medicalisation of women's experiences of sadness. The third theme was the role given to personal narrative, and despite personal stories being a feature on all of the sites bar one, such experiences are relegated to adjunct and secondary knowledge. Finally, and surprisingly given recent policy recognition of the gendered nature of depression, there was little reference to women's experiences and women's knowledge of depression and no links to sites that address such issues.

The most frequently mobilised discourse of depression across all sites was that of mental illness, with reference to biomedical causality (e.g. chemical imbalance in the brain) and psychological disorder (e.g. lack of coping skills). All websites referred to the DSM definition of depression as the source of authority. This discourse about causality directly connects the definition of depression as illness to 'treatment' options requiring particular professional intervention (within the field of mental health and medicine). This statement on Depression.net is an example.

*"Ultimately, however, you might either have to accept living a less happy life or accept that some form of professional intervention is necessary."*

All the websites, except Depression.com, contained some personal narratives that articulated rich phenomenological accounts of depression, side effects of anti-depressants, social factors and relationships, satisfaction and dissatisfaction with professional advice. In June 2003, after this study was completed, beyondblue established a new section of their website called bluevoices – a place for people with depressive illness to come together.

Although research on mental health literacy (Jorm 2000) has shown that Australians contest the privileging of pharmaceutical solutions, the misgivings of individuals who report negative experiences with anti-depressant medication are not really addressed in many of the replies by psychiatrists published in chat rooms. This is despite the fact that chat rooms and message boards are dominated by people's discussions of their problems about managing the side effects of antidepressants. The power/knowledge relations informing such discourses position self-care approaches to depression as invalid. Although the Bluepages site does present a huge range of 'treatment' alternatives (yoga, exercise, relaxation, vitamins etc), self-care strategies are generally devalued on the basis of not complying with evidence based on randomised control trials.

Throughout the websites the most recommended solution is treatment with anti-depressant medication, although cognitive behaviour therapy is also advocated. While alternatives to such approaches are mentioned on sites, particularly by 'consumers', for example in the "What works for me" section of Depression.net, self-care strategies appear as secondary to professional expertise. Potentially at least, this reinforces a dependence on professional practices and silences the voice of the depressed person. Curiously there is little regard for how women's knowledge about what works for them could constitute a kind of evidence or knowledge base for alternative practices.

Despite the recognition of the gendered nature of depression in policy there was surprisingly little reference to women's experiences of depression or gender issues on the most commonly accessed sites. For example, on beyondblue.com, we found only three brief gender-specific comments: one referring to the statistical imbalance in diagnoses of depression relating to gender, one to menopause as linked to depression and one mention of post-natal depression with a discussion forum. There was no discussion or acknowledgment of discourses about the socio-cultural determinants of women's depression (such as are discussed in NSW Health 2002 for example) or links to sites outside Australia that address these ([www.apa.org/pi/wpo/women&depression](http://www.apa.org/pi/wpo/women&depression)). Thus an individual who is presumably male (and white) is the universal subject addressed on these sites. While people's stories may refer to alternative representations of the 'causes' of depression, such as women's experiences of abuse, expert discourses about depression as illness are superordinate. The limitations of pharmaceutical anti-depressant solutions are clearly observable, and have been extensively critiqued within the literature (Healy 1998, Sparks 2002). From our website analysis it appears that it is easier to provide a diagnosis and a drug treatment than to attempt to address gender inequities in the home, work and leisure, tackle poverty or explore alternative understandings of women's emotional distress.

In contrast, on the personal web site we selected - Lifting the Fog, the creator of the site is a woman who has herself been diagnosed with depression, and she does foreground sociocultural factors that have been significant in her experience of depression. We include some extracts (see appendix) from her narrative to illustrate how the biomedical model of depression oversimplifies and ultimately limits how we might interpret and respond to that experience. However, this site is less likely to be accessed by women as it comes in at rank 15 when searching for information on depression.

In no place on the commonly accessed sites is the nature of women's emotional lives questioned, and questions of meaning or existential uncertainty are not taken up, even though many personal stories identify these things as issues. Depression is presented as something that happens to people as a result of their biology or distorted thinking patterns and that therefore they are denied agency by being subjugated to the expert. Depression is presented as a state of 'lack', a chemical imbalance that manifests as somatic and is treated with drugs to 'balance out' the lack. The body here is presented as biomedical, with no 'reading' of the depressed body for signs of cultural dis-ease.

Because depression websites are largely silent about gender, women are presented with a choice to either identify with medicalised explanations or to refute this reality and search elsewhere. These sites have medical credibility and explanations that contest their authority become subsumed and invalidated. If you don't agree with the construction of your experience as depression designated by the DSM you simply have 'poor mental health literacy'. This implies that women who refute the established discourses about depression are ignorant of or 'non-compliant' with expert discourses about depression. As women, our knowledge of self, emotions and social life becomes 'subjugated knowledge' within the discursive terrain of biomedicine and therapy. For some women there is a comfort in having a sanctioned explanation for difficult to explain sadness or despair. Diagnosis provides a kind of order to the complexity of emotional distress and promises a kind of meaning for one's feelings that is acceptable in a culture where pain, loss and other so-called 'negative' emotions are denied and covered up. But in normalising depression dissent is mollified and social change diverted.

In addition there are no suggestions about the need for a gendered solution to the 'epidemic' of depression, nor is there a linking of that epidemic to cultural contexts reflecting the effects of neo-liberalism (Pusey 2003) and the loss of community (Seligman 1990). Seligman argues that a culture of individualism at the expense of the common good is the reason for the 'epidemic' of depression. In contrast, depression policy is focused on building mental health literacy, with such literacy defined as accepted knowledge and beliefs about mental disorders which will aid individuals and professionals in recognition, management and prevention. The information presented on these depression sites is about having people adopt a biomedical disease explanation of depression, and not necessarily about building health or effecting social change.

### **Reflecting on our interpretive practice**

The focus in this discussion is on the issues that we have struggled with in our interpretive, or as we prefer to say our deconstructive, practice of reading depression websites. As feminist researchers our practice is not that of the supposedly neutral interpreter searching for a universal, essentialist account of some phenomenon or one true voice. Various uncertainties came to the fore in the project. What we heard when we examined the discourses on depression on the web were not only the many competing voices, but also the absences. How is the absent voice to be represented? Another uncertainty came with the diversity we found, not only in the material, but also in the interpretation. How were we to acknowledge and deal with such diversity, giving recognition to difference and not smoothing it into a meta-narrative. Further uncertainty came with the practice of

reflexivity, and the extent to which we recognise and are transparent about our motives and perspectives. Also associated with notions of evolution come uncertainty associated with a medium like the Internet, which changes rapidly, evolving continuously. We have to accept that the study we do takes place at a particular point in time, from a particular perspective. The chief source of uncertainty that we have chosen to focus on in this paper is to do with the question of how to represent voice. As feminist researchers our practice is not that of the supposedly neutral interpreter searching for a universal, essentialist account of some phenomenon or one true voice.

We hear the voice of authority, the psychiatric profession, the voice of people with depression describing an experience, and the voice of people struggling with alternative discourses to those that dominate the sites. We 'hear' too the absent voices, the subjugated knowledges that are excluded from the sites. Our concern has been described by Walkerdine when she says,

*“ I have tried to focus on the relation between regulation and the gaps and silences, the places in which material/discursive relations can be spoken another way, so that another story of subjectivity may be told” (1997 p170)*

Another issue of voice is that of acknowledging our different voices in the interpretation, not smoothing over our diversity but finding a place for difference. To our analysis of the material we bring different questions, different knowledges, and different positions as women and as academics coming from very different traditions of what counts as knowledge. Yet another issue of voice is how we represent the absent voice drawing as we do on other knowledges than that represented in the site. The dispassionate researcher with a completely open mind about what the research is likely to find is, we believe, as big a myth in interpretive research as we have come to understand that it is in hypothetico-deductive paradigms.

With such diversity of voices, uncertainty arises to do with issues around representation and interpretation, the balance between them. As researchers we have a responsibility to bring what we find together to describe a picture, and tell a story, that resonates with our audience. We need to find ways of doing justice to the many different voices, ways of giving voice to difference whilst simultaneously creating a common thread that draws everything together so as to make a narrative sense.

When communicating with a variety of audiences over time, we also see uncertainty in the nature of research as being in flux. There are continuous, ongoing dialogues in any research project of this type, with dialogue between the researchers, between the researchers and the material, between the researchers and other knowledges, and between the researchers and various audiences over time. Whilst this does have to be accepted as a part of the evolutionary process of the research project, uncertainties are raised to do with representation of this ongoing dialogue, and knowing when the project has reached completion, accepting when we have 'done enough'.

Finally, there is the issue of how we make women's voices heard beyond academic circles. As feminist researchers we have a responsibility to 'make known' our findings in ways that benefit women. Fine et al's comment that, as interpretive practitioners, "we all write in a world not (necessarily) prepared to hear" (2003 p199) applies equally to new media such as

the Web as one of us found when we attempted to place a critical comment about a site on that site only to be censored! We need however, to use such media and challenge the current lack of recognition within academia for using non-academic avenues for publishing. We also need to be aware of and challenge the distaste within much of academia for being passionate about our research, to be transparent about our 'biases' but to contest claims that taking a position and being passionate invalidate our arguments.

## **Conclusion**

Acknowledging the importance of the media in increasing mental health literacy, and with an interest in exploring how popular media texts mobilise meanings about depression for women, we began a funded study of popular women's magazines and websites about depression. The focus was on the discursive construction of depression, and its effects on how we as a society come to know, define and classify this experience. Through applying a material-discursive approach we are attending to women's emotional, embodied and profoundly social experiences. We seek to render visible the power-knowledge relations that shape women's identity, the role of the lived and embodied aspects of everyday life, and the forces that shape how women come to think and feel about themselves – that shape the construction of their subjectivity.

In this paper we have focused on our 'reading' of the websites, concentrating on six sites that an Australian woman would most easily find herself. This deconstructive reading shows the dominance that is given to the voice of scientific authority, the ways in which women's experience of sadness is medicalised, the lack of attention that is paid to gender, and the adjunct role that is given to personal narrative. To illustrate this last point referred to one of the sites in which a woman tells her personal story of depression, a story that pays strong attention to the social and contextual factors, and that details limitations of medicalised understandings of depression.

In this paper we also reflected on the interpretive uncertainties relating to the representation of women's voices in qualitative research, and identified the five main themes as being voice, absence, diversity, reflexivity and change. We focused on voice, and discussed how our position as feminist researchers is not that of a supposedly 'neutral' researcher, searching for a single truth, but rather a search among differences, for suppressed and subjugated knowledges. We also recognised the value of our own different voices, and how we have to find ways to acknowledge these differences rather than smoothing over diversity. Dealing with diversity raises its own issues, particularly when there are so many competing voices threading through the discourse. We need to find ways in which to acknowledge difference, whilst also recognising our responsibility as researchers to present a coherent story that persuades and resonates with its readers. Whilst doing this we also recognised the need to see our research as a project in a continual state of flux, with ongoing dialogue taking place in many ways and at many levels. This uncertainty raises challenges in knowing how far to go, what to incorporate and when to say that the research has 'done enough'. Finally we continue to reflect on our role as feminist researchers, and on our participation in ongoing critical conversations about gender. Our critique of the dominant construction of depression as a biomedical phenomenon is part of those conversations, where we see the ways depression is constructed as a profoundly political

issue with implications for professional practices, policy directions and mental health promotion strategies.

## Websites

### Appendix 1 – Addresses of the websites used

DepressioNet	<a href="http://www.depressionet.com.au/">http://www.depressionet.com.au/</a>
Depression.com	<a href="http://www.depression.com.au/">http://www.depression.com.au/</a>
Bluepages	<a href="http://www.bluepages.anu.edu.au/">http://www.bluepages.anu.edu.au/</a>
Beyondblue	<a href="http://www.beyondblue.org.au/site/">http://www.beyondblue.org.au/site/</a>
Lifting the Fog	<a href="http://members.ozemail.com.au/~kap/depress.html">http://members.ozemail.com.au/~kap/depress.html</a>
PaNDa	<a href="http://home.vicnet.net.au/~panda/">http://home.vicnet.net.au/~panda/</a>

## Appendix 2 – Lifting the Fog (<http://members.ozemail.com.au/~kap/myex.html>)



### MY OWN EXPERIENCES



*I have probably suffered from a form of depression since I was about 7 years old. At that time my world fell apart. My father was injured in an horrific accident which involved the timber truck he was travelling in going over the side of a mountain. He was in hospital for 12 months.*

*During that time I was looking after my 7 month old baby sister while my mother visited my father in hospital. I was pushing her to sleep in her pram outside on our verandah and I went inside to get a drink. The young girl who lived next door (and who was intellectually disabled) came over and picked my little sister up out of her pram. When I came back outside, the girl panicked, dropped my little sister and ran. Donna received massive head injuries and died two weeks later.*

*My whole world fell apart. ...*

*We lived in a country town. The local doctor prescribed Valium to calm me down. He kept prescribing valium for 7 years. As a result I do not have a child hood. I don't remember much at all. I was always in the haze of a valium induce stupour.*

*It wasn't until a new "modern" young doctor came to town when I was 14 that I was "eased off valium" (in a period of 3 days can you believe it). The withdrawal symptoms were horrendous, but nobody bother to explain to me why it was I was going through such hell. ...*



*My next experience came when my marriage fell apart when I was 24. For two years after that I was "crazy". Angry all the time. Tired, but I couldn't afford to be. I had a 5 year old son to support and the rent to pay and the housework to do etc etc. I was prone to bursting into tears. I was suffering from pain in my back - my period pain was excruciating....*

*I struggled on. Life seemed to get a bit better. I met a wonderful man and we got married when I was 28. My job got progressively more responsible. I like my work and as I felt more comfortable and settled in my life than I had for a long time, I decided that I was good enough at my job to study law and get paid as a solicitor for doing the same kind of work I was already doing.*

*6 months later, my boss (whom I adored and had on a pedestal as a father figure/mentor) decided that after 5 years of working together, it was time he "hit on me". He expected me to sleep with him !!. I couldn't believe it. I was devastated. I had to leave my job. I cried for what seemed like months. All the aches and pains started to come back again.*



*I struggled on. Found a new job, kept up my studies and tried to deal with the ever increasing rebelliousness of my now teenage son. He got into a few troubles with the law - nothing too serious or for which he was ever charged. He was head-strong and we were butting heads almost every day. ...*

*Then one day at work, one of my bosses made a passing comment about my "delinquent son". He meant nothing by it, just a tease. But I started to cry. I couldn't stop. Not even having a cup of coffee or a cigarette in my mouth could stop the tears from falling. I was still crying at 2.00pm at*

*the end of lunch hour, so I went home*

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*I sat in the middle of my loungeroom floor and continued to cry. I thought "this is it Kerrie - you've gone over the edge girl - you need help". I opened the phone book and a name just seemed to jump out at me. Maybe fate intervened to give me that name because I really didn't know what I was doing or who I was looking for to help me. But the "CRISIS ASSESSMENT AND TREATMENT TEAM" seemed to be what I needed.*

*They were a godsend. They sent a counsellor around to my home. He sat with me and talked with me through all the tears. He gave me a medication to calm me down (a benzo as it happens but I didn't care by then). He arranged for me to see a doctor through their service. He came around every day for two weeks with my anti-depressant medication. Then every second day for two weeks, then once a week for another month. Only then did they deem it safe for me to handle my own medication and to see an "outside" psychiatrist to continue therapy and treatment.*

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*I've learned a lot about depression since then. A number of medications have not worked for me, including Aurorix (Moclobomide - a newer MAOI type drug) and Prozac (fluoxetine an SSRI drug). I experienced bad side effects with the anti-psychotic (or mood stabiliser drugs) Nortryptoline. I'm now taking Aropax (paroxetine known as Paxil).*

*My head is clear at least on this drug and the fog has lifted. (I couldn't have typed this story otherwise). I'm experiencing incredible insomnia and will have to deal with that next, but I'm reluctant to give up this drug because I am at least clear headed now. And to someone who has always prided themselves on their clear thinking, logical mind, and who has been through the experience of "losing that mind", having it back is almost a miracle.*

*I'm still struggling on. I've been told that because of my history, I will probably need the intervention of antidepressants for most of the rest of my life.. I'm not resigned to that yet. I do a lot of my own research and don't just blindly depend on what my psych tells me. What I'm learning is that the whole medical profession only "thinks" that causes of depression include an imbalance of certain neuro-transmitters in the brain, that some imbalances are possibly genetic, and that certainly environmental factors appear to play a part. ...*

## **UPDATE**

*I've decided to "86" the medication - I just got to the point where I'd had enough. My "intuition" was that it was time to go chemical free and I would probably be OK.*

*When I made the decision it had been 2 years, 2 months and 8 days since I took my first anti-depressant tablet. Initially the medication did bring me out of the major depressive episode. After about 3 months following my complete crack up, I had returned to some semblance of normality and was able to at least function again, but my mind was not mine anymore! ....*

*I've read that, even without medication, a major depressive episode will usually "right itself" within a two year period so I concluded that I should give myself the chance to be ME - not this semi-person whose functionality depended on the levels of drugs in my system. If being drug free doesn't work and I slip back into a major depression, then I don't think I would have lost that much in the quality of my life the way it is at the moment. If IT happens again I would even be prepared to take*

*another SHORT TERM COURSE of anti-depressants. BUT NEVER AGAIN will I subject my body, and particularly my brain, to the bombardment of a chemical cocktail as I have over the past two years. ...*

*The horrific symptoms include "meteorite strikes" in my brain that last anywhere between a few minutes and a few hours. It's like a bombardment of split second oxygen lapses to the brain. I feel nauseous and suffer the feeling of vertigo the whole time these "meteorite strikes" are occurring. At the same time, I get these pounding palpitations in my chest and neck - I can feel the arteries in my neck beating like a bass drum and at a rate which cannot be healthy. ...*

*(Just in case you are wondering I am still under the supervision of a psychiatrist, and although I don't think he truly believes that I should discontinue medication, because of my past history, I think he is astute enough to understand that it's my body these drugs are affecting and ultimately MY decision whether to take them or not). ...*

*So, for now, I am feeling good about my decision to quit medication, and MORE IMPORTANTLY, I'm feeling good mentally and emotionally. Once the withdrawal symptoms stop, I fully expect to feel good physically again too ...*

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