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Counselling Women Whose Lives Have Been Seriously Disrupted by Depression

What Professional Counsellors Can Learn from New Zealand Women's Stories of Recovery

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Abstract

This article presents some of the wisdom emerging from a study of the narratives of 18 New Zealand women whose lives had been seriously disrupted by depression. While a huge body of research exists addressing recovery from depression, most of it has focused on the dominant professional solutions of medication and therapy. In this study, the knowledge comes from women who found support for recovery outside the "expert" mainstream. Counsellors can learn from the "lay" solutions and understandings experienced by these women. The major conclusions drawn from the analysis of the stories are discussed in this article. These emphasise the gendered and holistic nature of depression and recovery, and the importance of distinguishing between "chocolate" solutions that address the symptoms, and "meaning-making" solutions that address the deeper matters that often underpin depression. The findings also challenge the need to distinguish between a major depressive disorder and dysthymia when supporting women to find their own formulae for recovery.

Keywords: depression, women, recovery, narrative inquiry, counsellors

In the forty years of my professional life, I have been a teacher, residential social worker, secondary school counsellor, counsellor of tertiary students, and academic supervisor for postgraduate students.[1] Throughout these years, I have been privileged to hear many stories of women whose lives have been disrupted by depression. They have told recovery stories of courage, creativity, insight, persistence and hope.

Professionals have offered medication, hospitalisation and counselling, but at the same time the women have worked hard at seeking out lay solutions and finding combinations that worked best for them.

I have heard these stories because of my position as counsellor or friend, and have not been able to share them formally with other professionals. I have, however, frequently sought and been given permission to pass on the "wisdom" of one woman to another, without revealing the identity of my wise teacher. As I read more published research about depression and recovery, I wanted women's stories to be heard alongside the more "privileged" stories recorded by medical and psychological professionals about their "expert" interventions and treatments. I decided, therefore, to undertake research for a PhD during which I would collect and analyse the stories of women whose lives had been seriously disrupted by depression, yet had recovered. I especially wanted to hear what women had discovered that contributed significantly to their recovery but did not depend on "mainstream" professional help.

This article presents and discusses some of the findings of the research project and considers the implications for counsellors.

Conducting the research

In this research project a narrative inquiry approach was used, and 18 women told their stories. The women self-identified as having had lives seriously disrupted by depression, and they believed that their recovery involved things outside mainstream medication or therapy. Advertisements seeking to recruit participants for the project were placed in a range of community settings.

Narrative inquiry is a valuable way of exploring the "meaning created by the individual as she or he constructs it in a social context" (Plunkett, 2001, p. 151). Crossley (2000) argued for the relevance of a narrative approach when one wants to study "self and identity" (p. 10), while Langelier (2001, p. 700) noted the value of narrative in researching "the lives of the ordinary, the marginalized, and the muted" who are able to "claim identities, and 'get a life' by telling and writing their stories." Bruner (2002), a key theorist in this approach, emphasised the contextual and meaning-making aspects of narratives:

> We constantly construct and reconstruct ourselves to meet the needs of the situations we encounter, and we do so with the guidance of our memories of the past, and our hopes and fears for the future. Telling oneself about oneself is like

> making up a story about who and what we are, what's happened, and why we're doing what we're doing. (Bruner, 2002, p. 64)

Narrative inquiry is particularly relevant for a study of depression and recovery because of the loss of meaning that accompanies the worst experiences of depression. Stories of depression are "tellable" by women. "Depression" is not only an "expert" label created by professionals, but also a common, socially constructed label for various types of distress. Fee (2000) proposed that at this time in Western society, the "clinical syndrome" of depression is particularly available to become a part of "self-construction" and "self-definition" (p. 75). The "languages of depression" are no longer confined to experts in the mental health profession, but have become "social objects" with "personal and collective significance." People know about depression and can incorporate it into the stories they tell about themselves.

Janet Stoppard, an eminent Canadian psychologist, has been involved in a significant body of qualitative research on women and depression (Stoppard, 1989, 1997, 1999, 2000; Stoppard & Gammell, 2003; Stoppard & McMullen, 2003). She argued for a "material-discursive" understanding of depression that is consistent with the work of Jane Ussher (2000) and is informed by a social constructionist, critical and feminist understanding. Such an approach acknowledges the contextualised, embodied, complex nature of depression, contrasting the perspective of this method with positivist research related to depression, which often "problematized women's experience, reducing it to a contextualized individual pathology" (Schreiber, 2001, p. 86). This theoretical understanding of depression and the research carried out by Stoppard, Schreiber and others, based on a respect for the knowledge of women who have lived with depression, encouraged me to seek wise and informed women to tell their narratives of depression and recovery.

At the time I conducted the interviews, the women ranged in age from 32 to 70 years, and their experiences of depression had occurred between the 1950s and the 1990s, with the worst periods clustering in the 1980s. When interviewed, 12 of the 18 women were in committed, stable, long-term relationships, including two with same-sex partners. Thirteen women were in paid work, mostly of a professional nature, and 15 had a tertiary educational qualification. For most participants, this career path and education had been achieved either as part of their recovery or following on from recovery. Six of the women had migrated to New Zealand as adults. Two talked of the importance of their ethnic origins: one identified as Jewish and the other as having Māori ancestry.

The women's stories

I invited stories with an open question: "Can you tell me the story of your life with depression?" I wanted to be able to analyse the data both in terms of *what* was said and *how* it was said. The stories settled into five broad areas. At the centre of every story was a vivid telling about the worst disruption. I will use the women's words to illustrate aspects of the findings. The names used are pseudonyms.

Disrupted lives

I wondered whether the women might have experienced sadness and distress but not severe depression. This concern was unfounded. The worst times for all these women were truly desperate and terrible. They each could have earned a diagnosis of major depression. Twelve had seriously contemplated, planned or attempted suicide, and many attempts remained incomplete only because they were interrupted. Many of the participants were prescribed antidepressants, and more than half were hospitalised or under the care of community mental health professionals during their worst times. One received ECT.

Frank (1995) described three categories of chronic illness narratives: restitution, chaos, and quest. The women's stories in the worst times resembled Frank's "chaos" category. Such stories were hard to listen to. They had "no narrative sequence, only an incessant present with no memorable past and no future worth anticipating" (p. 99) and they revealed "vulnerability, futility and impotence" (p. 97). Many women spoke of often being curled up in a foetal position at the worst times. They felt helpless. As Marge said, *I don't want to go on; I can't bear to think of me spending the rest of my life on this earth. And—wishing I'd never been born.*[2] Their lives lacked meaning and, like Kate[3], they felt *totally unworthy of everything.*

Jolly good reasons

All the women mentioned what Naomi called *jolly good reasons* for depression coming into their lives. There were recurring themes about reasons, but there was also variety. Some women spoke of being born with depression. Elizabeth, for example, saw it as a familial tendency running back through generations. Karen linked depression with her physically disabling condition. Naomi and Hine related it to their cultural identity. Naomi said, *Life is not to be enjoyed, life is to be endured. This is the message I've had from day one. That—and all my history, my ancestry.* Referring to her Jewish heritage, Naomi talked of her enduring experience of a life without joy as being *cultural depression.*

Much of the vast body of research on the "causes" of depression notes the link between depression and experiencing violence or abuse. This link was evident in many women's stories. Stories of loss and disappointment recurred. Common was the disruption of a "meaningful" life, through the loss of career, fulfilment, a significant relationship, or a sense of self-worth.

Seeds of resilience

Unexpectedly, all the women talked about resilience. They highlighted personal qualities, interests, abilities or relationships that existed before depression and that were available to support their recovery. I include Katy's story because as a counsellor, I would be tempted to interpret it as a "reason" for depression. Katy, however, was clear that this story was about enduring resilience. I present the story here in poetic form. When I transcribed the text into poetic rather than prose form, I was able to approach it "more slowly," to pay attention to "patterns of sound, image, and ideas" and to experience "more emotional engagement" (Kendall & Murray, 2004, p. 68).

Katy at boarding school, aged ten years
I remember lying in bed one night,
and with the blankets over my head,
and a handkerchief stuffed in my mouth,
so I wouldn't make a noise,
and crying and crying and crying.

Wondering why people didn't like me.
And I finished crying
and I started thinking.
And I thought…
What's wrong with me?
There's nothing wrong with me.
I may not be the same as everybody else
but I'm not—

I don't have ten heads. I'm not spitting out of turn,
or farting in the corridors
(excuse the language).

I'm sort of a quiet little girl.

And, if there's nothing wrong with me,
and the good Lord made me this way,
possibly he loves me this way.

So they've got the problem,
not me.

Settled.

If they don't like it.
TOUGH!!!

Katy, in her sixties, introduced herself as a *feisty old crone*, and in this "poem" she showed the resilient spirit she had when she was only ten. She was feisty throughout her narrative, fighting through the most difficult times, including when she pulled away at the last minute from securing a rope to hang herself.

Other women related developing coping strategies in response to trauma. Naomi learned to *dissociate*, enabling her to endure until she could better control her life. Ruth learned to fill her life with *doing* and continued to draw strength from doing physical and creative activities.

Many women discovered mentors who fostered developments that had lasting significance. Anne had an artist mentor who encouraged her creativity. Christine called on her psychiatrist at difficult times over decades. Ruth talked of her counsellor and mentor as *my Merlin*. From these relationships, these women discovered that they were intelligent and capable of high levels of education. This recognition of their intellect and support for a sense of entitlement to be clever and educated strengthened their resilience and aided recovery.

Spirituality was another common aspect of resilience. Katy's story speaks of the strength she found in a Christian God, but for most participants, spirituality seldom involved organised religion. Astrology was an important *meaning-making system* that Anne *held onto like grim death*. Hine reconnected with her *good self* and her *god self*.

Crawling out of it is so hard

At some point the women began to seek solutions, but they had long periods of "doing nothing." Many expressed regret that "nobody noticed." Kate commented that as a young teenager, she wasn't *just a moody* adolescent; her moods *were actually the onset of depression*:

> *It just, it never kind of got questioned…At the time I was thinking—Yeah, I thought very strongly that it was bad. That nobody picked it up. That nobody picked it up…that I was allowed to go on for, like, fifteen years, and no one ever really queried it. I mean, if you'd been limping or dragging one foot, someone would have noticed. But because it was emotional, it was just all brushed aside and you were expected to cope.*

Fortunately, the distress of each of the women in the study was finally addressed, and the search for recovery began. Friends or family initiated some possible solutions; others were self-initiated, and serendipity was important. Many of the "false starts" involved unhelpful "professional" solutions offered by medical or psychological experts.

The unhelpful medical solutions generally involved prescription of antidepressants, which some described as *useless*, and others felt the doctor *probably should have gone deeper, and scratched the surface*. The lack of depth was also a concern with some false starts made by counsellors, although counselling was a helpful part of recovery for some women. Jane called Lifeline and talked with someone she described as *an absolute dweeb who didn't tell me anything*. Isobel was referred to a community mental health centre after a serious suicide attempt and said she had *some girl as a counsellor*:

> *I thought, you don't know anything I need. You're just too young and I just said to her, "Look, I'm not coming back." I said, "I feel as if I'm helping you rather than you're helping me."*

Karen also had a very unfortunate mismatch with a therapist when she was hospitalised in her late teens and was allocated an *extremely Freudian chap* whom she described as *appalling*. She took charge of these compulsory sessions:

> *In the end all I could do was talk about art and literature and history and he would glaze over and it would shut him up and I'd just prattle on to the end of the session. Then I'd be able to go away. So it was pathetic. I mean, I'm sure it made me worse.*

Marge went to many different counsellors but found them unhelpful because they didn't really *get into your soul*. Naomi's early work with counsellors *didn't manage to get down into that soul, you know, place inside*. Hine recognised that while many counsellors can be *empathetic*, they lacked the *real skills to shift you into being able to*

be proactive about your life. Like Karen, she experienced therapy within a psychiatric hospital, but found it *superficial* and unable to *get close to anything deep-seated.*

Linda paid for therapy for more than two years, and came away from each session feeling terrible. Eventually, she risked going to a different counsellor and found that her problems related to a physical matter that was fixed with minor surgery.

> *It had always been talked about in a head way. That I had some sort of problem with having sex or something…Some of the stuff that therapists come up with…makes me so angry. I just think, how can you drop that onto people, and sort of imply that just because they can't do some physical thing, that there's some emotional correlation to it. And I—OH—I still have times when I feel angry about it. And how dare they, how dare they ply you with information and then leave you feeling so gutted. Leap to conclusions without realising what might be going on.*

Other false starts involved doing physical exercise, which for Marge was *the last possible thing I want to do when I am depressed*, or using self-help books, which Christine *hated* because they were *behaviourist* and she was not.

Just as therapy, medication, and exercise did not work at all for some of the women, for others they were part of the pathway to recovery. It is thus very important to recognise that different things work for different people. This was clear from the narratives of recovery and the women's formulae for "getting it right."

Getting the formula right

Each woman had a particular combination of things that assisted and maintained her recovery, even if depression continued as what Ruth called *an old friend.* The research focused on "lay" solutions, situated outside the mainstream medical and psychological treatments. Nevertheless, many of the women incorporated medication and/or talking therapy into their formula for recovery. Marge and Ruth acknowledged that some form of medication would probably always be a part of their lives. For others, it was seen as a helpful form of symptom relief in the early stages of recovery. Complementary medicines, including homeopathic cures, were also important.

Psychosynthesis was the only identified form of talking therapy mentioned as helpful. Four people acknowledged its value, but others, when they described finding the "right" therapist, stressed the importance of deep understanding. Marge asserted the importance of having a therapist who could *really get to the bottom of what it was*

that was going on. Hine commented, *A lot of people can be empathetic but it takes real skills to be able to shift you into being able to be proactive about your life.*

Activities were present in most women's stories. Kate chose belly-dancing, Fiona took up a lifelong dream of being a motorcyclist, Naomi walked, and Jane took up ocean swimming. Hine wrote music and sang, Isobel played the piano and embroidered, Charlotte sewed, Hannah acted, and Christine and Kate walked in the bush.

Women's company was valued. Hine first found this support among patients in a psychiatric hospital, and Jane found it in a group for recently separated women. Naomi was in a violent relationship and rang a help line but was misunderstood and invited to become a volunteer telephone counsellor. The group of women she met through this unexpected offer became an important source of support. Kay realised she was intelligent, went back to tertiary education, and then became involved in a parent support group, commenting, *We had great fun. It just completely reinforced for me that women need other women. And a variety of women.*

Historically situated gender expectations were significant. Different positions were available to women at different times, and the changes related to second-wave feminism in the seventies were relevant. The dominant construction of women as wives and mothers in Aotearoa New Zealand in the 1950s and 60s had become more complex by the 1980s and 90s. In the late 20th century, women could call on stories of "women can do anything," including choosing not to have children, living in same-sex relationships, and expecting to have a professional career that could be combined with successful mothering. While these stories evolved, there remained a dominant narrative of woman as nurturer—woman as caregiver to friends, family, clients—but not caring for herself. Finding ways to build or rebuild a meaningful life and identity within the context of such gendered expectations was a significant aspect of recovery for most of the women. Entitlement to such aspects of life as education and self-care, as well as more choice about having and nurturing children, formed a key part of one of the four conclusions.

Some important learnings

In keeping with narrative inquiry, much of the analysis of the women's stories rejected "grand" and "totalizing" narratives and focused on "individual subjectivities" (Anderson, 2004, p. 238). As Frank (1992) advocated, I tried to bear witness to the "embodied" and "eccentric" nature of the women's suffering and the deep meaningfulness of their recovery (p. 483). I hope their wisdom will lead to change and to more

effective and respectful clinical practice. I will present four general themes that emerged from the women's narratives and then create some recommendations for counsellors.

The gendered nature of depression and recovery

These 18 women's experiences of depression and recovery often concerned "gender." The stories of the worst times involved vivid and heartbreaking descriptions of "female" contexts and practices. Kay talked about her experience of depression after the birth of her first child:

> *One afternoon I was in my dressing gown, in the hallway, surrounded. Sitting on the floor, surrounded by a vacuum cleaner that I was trying to put together to vacuum the house. And just thinking—oh this is so bloody awful. This is—oh God—dreadful. Why didn't I get another dog instead of a baby…*

Traumatic experiences both during childhood and as adults were often mentioned. Three women specifically spoke of intimate male partner violence. Naomi said:

> *I'd taken out an injunction order…and oh my God he was following me, and—I was sick. I was vomiting up. You know, it was horrible, it was horrible. It was absolutely…it was a nightmare, it was a horror movie.*

Ruth was very clear about the gendered nature of depression, talking of *the rage and anger, the role-typing of women*, and reflecting that *depression and women have an interesting partnership.* Many women were denied the chance to make meaning of their lives as children, adolescents, or young adults because of the denial of their *intellect* and the expectations that they would offer *total feminine support* to the men in their lives. Recovery involved developing an awareness of the impact of such gendered expectations and reshaping their lives to actively meet their own identity needs, claim female entitlement, and honour their intellect and talents.

Some solutions reflected options that may be particularly available to women. Kate became a "white witch" and took up belly-dancing; both of these activities were valued in part because they enabled her to enjoy the company of *wise women.* Chloe realised in her thirties that she could safely be a mother as well as a career woman. As a child, she had experienced violence and abuse, and only as she recovered did she feel entitled to be a mother herself. Financial restraints led women to find economic solutions that worked. Thus, Jane became an "ocean swimmer" and Naomi walked regularly.

Chocolate solutions and the creating/re-creating of meaningful lives

The women identified two different but overlapping kinds of solutions involved in recovery:

- the "chocolate" solutions which offer symptom relief;
- the discovery or re-discovery of a way of making meaning of one's life that resulted in a more lasting recovery.

The idea of chocolate solutions arose in a focus group of five participants who met on three occasions following the individual interviews. The group had been discussing the importance of classical music, astrology, and the idea of distress as a "spiritual emergency" (Grof & Grof, 1989).

Interviewer: *What is the difference between chocolate, cigarettes, good sex, and these other things you are talking about, like music and astrology?*

Ruth: *I think because it stimulates a deeper thing—if you're open to it. That's why it can be scary, and yet so powerful and healing.*

Naomi: *I'll tell you what's different—is that chocolate and the smoking—I mean, they, they stifle—it's comforting, it's great, and it's got its place, and I wouldn't be without it, but it actually puts a, it puts a lid on it, whereas those other ones open it, that makes it more OK.*

Chloe: *I know what you mean, it's sort of like—it's only a top layer—music's all. Everything.*

Anne: *Like, I can smoke—I can chain smoke—no trouble whatsoever. But, I, it doesn't do anything for me. I've still got this anxiety about linking in with something that gives it, a, a meaningful—the key word is meaning.*

Karen: *There's no meaning in chocolate.*

The group suggested that different responses to depression resulted in different kinds of relief. This analysis was supported by all the individual interviews. They were able to distinguish clearly between symptom relief and deep change, and were well aware that they needed both in order to live without serious disruption from depression.

Depression and recovery as holistic experiences

The women talked of depression in a holistic, contextualised way. In Aotearoa New Zealand, we are fortunate to have available Durie's (2003) Māori model of wellness.

> Depression and anxiety, for instance, may not be viewed as isolated areas of dysfunction but as indicators that the balance between emotions, social

> relationships, spirituality and the body has become distorted. That perspective underlies a relational approach to health and human understanding which is not easily accommodated within a disease or behavioural orientation. (p. 48)

Both the chocolate solutions and the meaning-making changes involved all aspects of being. The recovery strategies discussed throughout this paper indicate the holistic approach taken by these women.

The mirrored nature of the pathway into and out of depression

The analysis revealed a symmetry among the many journeys toward and beyond the worst times of depression. During the analysis, I represented the women's lives with depression graphically (Leibrich, 1998; Lieblich, Tuval-Mashiach, & Zilber, 1998). It emerged that when the women talked of life being suddenly disrupted by depression with little warning, the journey of recovery was similarly brief. When they talked of a lifelong or intergenerational journey into the worst times of depression, the journey out was correspondingly lengthy and complex.

Implications for counsellors in Aotearoa New Zealand

A central implication of this research for counsellors is that we need to consult with the women who are our clients. This consultation needs to involve genuine acknowledgement that they are "experts on themselves" (Leibrich, 1998, p. 266).

The times of worst disruption

In the "chaos" of the worst times, consultation is difficult. The women talked of the importance of being kept safe, which may involve suicide prevention, or support to escape an abusive relationship. Medication may help some women but not all. Antidepressants enabled Isobel to get out of bed and dressed. However, the side effects prevented her playing the piano or embroidering, which gave her life meaning. She chose to abandon medication and to accept the support of friends who came each day and helped her get up and dressed. She could then engage in her chosen, healing creative activities.

Jolly good reasons

All the women offered reasons for depression disrupting their lives. Their reasons coincide with those widely accepted as increasing the risk of depression (New Zealand Guidelines Group, 2009, p. 3). They included childhood abuse, financial difficulties,

and the loss of significant relationships. The gendered issues, discussed later, such as a lack of entitlement, and experience of intimate partner violence, are most likely to challenge the practice of counsellors.

Seeds of resilience

Katy's story reminds us to focus on the meaning that the narrator brings to her own story. It suggests that counsellors help women find their own "seeds of resilience" through such processes as the search for "alternative" stories. Whatever our theoretical underpinning, the women remind us to seek out the strengths they can draw on to aid recovery.

Crawling out of it is so hard

Counselling can do harm or good, and it can be "useless." A single negative experience of counselling can influence women to resist seeking help from "professional" therapists. We need to check regularly with our clients about their experience of our conversation and process, and be brave enough to acknowledge our limitations and to initiate appropriate referral. We need to understand that although cognitive behavioural therapy is widely recommended in official documents for the "treatment" of depression, it may not meet the needs of all women living with depression. Perhaps it is a "proven" treatment because of its ability to be "scientifically" researched, rather than because women find it the most effective form of counselling (Brettle, Hill, & Jenkins, 2008).

Getting the formula right

A substantial body of work by Brown, Harris and their colleagues (e.g., Brown, Lemyre, & Bifulco, 1992) supports the importance of "fresh start" activities in women's recovery from depression. Their work emphasised the situated nature of depression, and my research affirmed that life changes and fresh starts can assist recovery. As counsellors, we need to be alert to such possibilities and to resist the temptation to locate distress, including its causes and solutions, within the person at the expense of the inter- or transpersonal aspects of women's lives. The unique pathway to recovery narrated by each woman reminds us that on this journey, the woman is the "expert" on her own formula.

The gendered nature of depression

Research suggests that the incidence of depression is related to gender, with women being at least twice as likely as men to experience depression during their lifetime

(Fergusson & Horwood, 2001). Yet the most common directives for treatment promote medication and counselling, seldom suggesting that gender may be a factor in recovery. My research strongly supported the need to consciously involve gender issues when working with women. Men may also benefit.

Fiona's narrative includes a vivid example of what might work. As a child she had offered *female support* to her farming and motorcycling father and brothers. In mid-life, while experiencing the worst depression after her husband left her, she met a childhood friend. He challenged, *Tell me what you would really like to be doing now.* She responded, *ride motorbikes*, and he gave her a motorbike. This "fresh start" was central to her building a new life of fun and meaning and a new identity.

> *It is old women, young women, fat women, thin women, rich women, poor women, clever women and stupid women. There are…there's the smokers and the drinkers and there's the health addicts. And there's just every kind of women…And I just took my place. It was just fantastic.*

The participants all came to accept their entitlement to aspects of life denied them because of gender. Most significant was a right to be intelligent and well-educated.

Chocolate solutions and the creation of meaningful lives

The New Zealand Guidelines Group (2008, p. 67) has recommended that:

> First-line treatment for an adult with moderate depression is either a selective serotonin reuptake inhibitor (SSRI) or a psychological therapy (e.g., 6 to 8 sessions of problem-solving therapy or cognitive behavioural therapy [CBT] over 10-12 weeks).
>
> For an adult presenting initially with severe depression, the practitioner should consider a combination of antidepressant medication with a structured psychological intervention (e.g., CBT or interpersonal psychotherapy [IPT], 16 to 20 sessions).

My research suggested that successful "treatment" involves more than a combination of medication and talking therapy.

This implies that counsellors should be clear about symptom relief and also about more long-term solutions that can build a meaningful life. Women may choose to forego immediate symptom relief through medication in order to be "fully present" while working on "deeper" issues. The acknowledgement of "deep" psychosynthesis

work supported this. Linda's story offered a cautionary tale, however. Her story of "enduring" two and a half years of ineffective talking therapy before learning that a simple operation would relieve her major symptoms is a potent reminder to counsellors to work collaboratively with other disciplines.

The holistic approach

Durie (2003) noted Māori dissatisfaction with mental health approaches that focus on "symptom clusters, syndromes or isolated behaviour patterns" (p. 48). A holistic approach involves taha tinana (physical well-being), taha hinengaro (mental well-being), taha whānau (social well-being) and taha wairua (spiritual well-being). The spiritual, or transpersonal, associated with creating a meaningful life was part of every woman's recovery. It is important that counsellors attend to this aspect of depression and recovery.

Mirrored journeys

These findings suggest that it is important for counsellors to consider each woman's understanding of how she came to be living with depression. It is often suggested that the seriousness of the depressed experience should predict the treatment, but the worst times for these women were all similarly terrible, bleak, and chaotic. The recovery journeys varied greatly, and the idea of mirrored journeys was a helpful guide to which journeys might be long and complex, and which could be relatively straightforward.

Conclusion

This research and the women who took part in it have offered immeasurably rich learning to me as a counsellor, and hopefully have assisted some of my clients to recover from depression. I hope that this article will also enable some of my many colleagues to learn from the pain, courage, and creativity of the 18 women who shared their stories.

Notes

1 This research account is told in Jan's voice. It draws on her PhD research, which Lynne supervised. The article is authored by both Jan and Lynne.
2 All direct quotations from the women are in italics to highlight their contributions. Pseudonyms are those chosen by the women themselves.
3 Three women independently chose similar pseudonyms – Kate, Katy and Kay – and each therefore represents a different person.

References

Anderson, J. M. (2004). Lessons from a postcolonial-feminist perspective: Suffering and a path to healing. *Nursing Inquiry, 11*(4), 238–246.

Brettle, A., Hill, A., & Jenkins, P. (2008). Counselling in primary care: A systematic review of the evidence. *Counselling and Psychotherapy Research, 8*(4), 207–214.

Brown, G. W., Lemyre, L., & Bifulco, A. (1992). Social factors and recovery from anxiety and depressive disorders: A test of specificity. *British Journal of Psychiatry, 161*, 44–54.

Bruner, J. (2002). *Making stories: Law, literature, life.* Cambridge, MA: Harvard University Press.

Crossley, M. (2000). *Introducing narrative psychology: Self, trauma, and the construction of meaning.* Philadelphia: Open University Press.

Durie, M. (2003). *Nga kahui pou: Launching Māori futures.* Wellington: Huia.

Fee, D. (2000). The project of pathology: Reflexivity and depression in Elizabeth Wurzel's *Prozac Nation.* In D. Fee (Ed.), *Pathology and the postmodern: Mental illness as discourse and experience* (pp. 74–99). London: Sage.

Fergusson, D. M., & Horwood, L. J. (2001). The Christchurch health and development study: Review of findings on child and adolescent mental health. *Australian and New Zealand Journal of Psychiatry, 35*, 287–296.

Frank, A. W. (1992). The pedagogy of suffering: Moral dimensions of psychological therapy and research with the ill. *Theory and Psychology, 2*(4), 467–485.

Frank, A. W. (1995). *The wounded storyteller: Body, illness, and ethics.* Chicago: University of Chicago Press.

Grof, S., & Grof, C. (Eds.). (1989). *Spiritual emergency: When personal transformation becomes a crisis.* Los Angeles: St Martin's Press.

Kendall, M., & Murray, S. (2004). Poems from the heart: Living with heart failure. In B. Hurwitz, T. Greenhalgh, & V. Skultans (Eds.), *Narrative research in health and illness* (pp. 52–72). Oxford: Blackwell.

Langelier, K. M. (2001). Personal narrative. In M. Jolly (Ed.), *Encyclopedia of life writing: Autobiographical and biographical forms* (Vol. 2, pp. 699–701). London: Fitzroy Dearborn.

Leibrich, J. (1998). The healer within: A personal view of recovery. In S. E. Romans (Ed.), *Folding back the shadows: A perspective on women's mental health* (pp. 263–279). Dunedin: University of Otago Press.

Lieblich, A., Tuval-Mashiach, R., & Zilber, T. (1998). *Narrative research: Reading, analysis, and interpretation.* Thousand Oaks, CA: Sage.

New Zealand Guidelines Group. (2008). *Identification of common mental disorders and management of depression in primary care.* Wellington: Author.

New Zealand Guidelines Group. (2009). *Depression: There is a way through it.* Wellington: Author.

Plunkett, M. (2001). Serendipity and agency in narratives of transition: Young adult women and their careers. In D. P. McAdams, R. Josselson, & A. Lieblich (Eds.), *Turns in the road:*

Narrative studies of lives in transition (pp. 151–176). Washington, DC: American Psychological Association.

Schreiber, R. (2001). Wandering in the dark: Women's experiences with depression. *Health care for women international, 22*, 85–98.

Stoppard, J. M. (1989). An evaluation of the adequacy of cognitive/behavioural theories for understanding depression in women. *Canadian Psychology, 30*(1), 39–47.

Stoppard, J. M. (1997). Women's bodies, women's lives, and depression: Towards a reconciliation of material and discursive accounts. In J. M. Ussher (Ed.), *Body talk: The material and discursive regulation of sexuality, madness and reproduction* (pp. 10–32). London: Routledge.

Stoppard, J. M. (1999). Why new perspectives are needed for understanding depression in women. *Canadian Psychology, 40*(2), 79–90.

Stoppard, J. M. (2000). *Understanding depression: Feminist social constructionist approaches.* London: Routledge.

Stoppard, J. M., & Gammell, D. J. (2003). Depressed women's treatment experiences: Exploring themes of medicalization and empowerment. In J. M. Stoppard & L. M. McMullen (Eds.), *Situating sadness: Women and depression in social context* (pp. 39–61). New York: New York University Press.

Stoppard, J. M., & McMullen, L. M. (Eds.). (2003). *Situating sadness: Women and depression in social context.* New York: New York University Press.

Ussher, J. M. (2000). Women's madness: A material-discursive-intrapsychic approach. In D. Fee (Ed.), *Pathology and the postmodern: Mental illness as discourse and experience* (pp. 207–230). London: Sage.