

MANAGING DEPRESSION:
Stories of Patients and Their Families Pursuing
Mental Health after Psychiatric Hospitalization

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ABSTRACT

This qualitative research study was designed to follow-up with ten participants in a relapse prevention program at an inpatient psychiatric unit with a diagnosis of major depression for the purpose of determining their experiences post-discharge in practicing relapse prevention and in pursuing and maintaining wellness in their mental health. It relied upon narrative theory, theories of self-efficacy, and theories of depression to guide the research process as well as the field of knowledge about rehospitalization, relapse prevention, depression, and self-efficacy.

Participants described depression associated with loss, feeling helpless, powerless, overwhelmed and suicidal. They increased in their confidence of depression management as their depression got better and they actively managed it.

During the interviews participants expressed themes of connection, with participants feeling disconnected from themselves and others, wanting to be listened to, but feeling unheard or hiding their own voice, a loss of self with healing occurring through use of self, learning cognitively and experientially to manage their depression using specific self-efficacy skills and identifying the things that interfered with depression management. A relational theory of depression management, based on attachment theory is proposed and several suggestions for research and treatment are made.

DEDICATION

To the glory of God
Who created us for connection,
To all the participants
Who gave me the gift of connection,
And to my family
To whom I am eternally and lovingly connected.

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This research is about the importance of connection in people's lives. In many ways I have come to understand the importance of connection in my own life through this process. It is with a deep sense of gratitude that I wish to acknowledge the many people who are a part of this research because I am connected to them and they have chosen to be connected to me.

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It is out of one's roots that one grows, and surely I have an extended family that has provided me nurturance and sustenance. I am grateful for my Dad and my Mother, and my sister and brother, all of whom believed in me, encouraged me, and took time to listen to me in whatever way was necessary.

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This brings me to my husband. Al, I am not sure I can express the depth of my gratitude to you. This research is as much yours as mine, for you have stood by my side and never let me be discouraged. You have shown interest and caring not only in me, but also in the research itself. You shared the passion that I felt for the lives of these people and believed that their stories should be told. At considerable sacrifice to yourself, you always encouraged me to do the work. By your love for me, you have shown me what love is, and the only way I know to describe that is that you have been the living Christ for me. Thank you.

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CHAPTER I

INTRODUCTION

OVERVIEW AND PURPOSE OF THE RESEARCH

This research was based on a Relapse Prevention Program currently utilized by the inpatient psychiatric unit of Carilion Roanoke Memorial Hospital Rehabilitation Center. It was designed to follow-up with patients who participated in the program during their stay in the hospital and to determine what their experiences were after discharge in practicing relapse prevention and in pursuing and maintaining wellness in their mental health. It was also designed to ascertain from the patients what other methods of treatment they now believe would have been helpful for them to have received while they were in the hospital.

BACKGROUND OF RELAPSE PREVENTION

In 1964 the Community Mental Health Centers Construction Act was enacted with a goal of providing community based programs for care of the chronically mentally ill (Wan and Ozcan, 1991). Deinstitutionalization became the goal of psychiatric care, shifting the primary responsibility for the care of the mentally ill from the inpatient psychiatric hospital to outpatient community care (Johnson, 2000). Where length of stay in psychiatric hospitals was traditionally measured in weeks, months, or years, it is now measured in days, with the majority of treatment occurring in outpatient settings (Lieberman, Wiitala, Elliott, McCormick, & Goyette, 1998). The goal of treatment in inpatient settings has changed from personality restructuring to crisis stabilization.

Once patients were discharged to the community, a growing concern became readmission. Research has subsequently shown that briefer inpatient hospital stays are

not associated with higher rates of readmission (Hirsch, Platt, Knights, & Weyman, 1979; Lyons, et al., 1997; Thomas, et al., 1996). However rates of readmission remain high for patients with severe mental illness, such as schizophrenia, substance dependence, or chronic psychiatric disorders with an affective component, with estimates ranging from 30 to 50% during the first year after discharge (Klinkenberg and Calsyn, 1996).

Much research has focused on trying to understand the factors associated with readmission (Davidson, Stayner, Lambert, Smith, & Sledge, 1997; Haywood, et al., 1995; Klinkenberg and Calsyn, 1996; Lyons, et al., 1997; Mesch and Fishman, 1994; Owen, Rutherford, Jones, Tennant, & Smallman, 1997; Wan and Ozcan, 1991). Traditionally, the number of readmissions occurring within a hospital has been considered an indicator of quality of care, although the validity of using readmissions as an indicator has been questioned (Lyons, et al.; Kent, Fogarty, & Yellowlees, 1995).

In trying to prevent rehospitalization, hospitals have begun to use a relapse prevention approach (Davidson, et al.) Most relapse prevention research has taken place in chemical dependency treatment settings. Relapse prevention approaches for mental health usually entail educating patients and their families about the “nature of serious mental illness, the need for medication, the ongoing vulnerability to stress, and the use of problem-solving strategies to decrease stress and the level of ‘expressed emotion’ in the family environment” (Davidson, et al., p. 770). More recently, relapse prevention has begun to include teaching patients and families about the early warning signs of relapse and how to monitor symptoms. This approach, called “prodromal recognition”, has shown some promise in reducing relapse rates (Birchwood, 1995; Herz and Lamberti, 1995).

In February 1998, an interdisciplinary team from the inpatient psychiatric unit of Carilion Roanoke Memorial Hospital formalized and implemented its own relapse prevention program. Based on the relapse prevention principles associated with substance abuse therapies, the team developed a structured three day program of psychoeducational groups emphasizing the following themes: Day One focuses on problem identification, goal setting, and motivation enhancement by recognizing possible outcomes of change. Day Two focuses on patients' traditional responses to stress by offering groups on the relapse process, values clarification, and coping skills. Day Three helps patients develop a personal relapse prevention plan as patients participate in groups about relapse prevention, lifestyle management, and relationships. Each day also offers groups on therapeutic recreation which implement many of these relapse prevention principles in a therapeutic recreation format, and reflections groups, which provide patients time to process what they have learned for the day and to set goals. Patients are provided with pamphlets of materials for the topics of each day to help them reflect on those topics and to personalize their own relapse prevention plans.

In addition to the structured groups, patients have opportunity to incorporate the principles of relapse prevention into their personal time with the treatment team (doctors, nurses, social workers, recreation therapists, etc.) and in their family meetings.

RATIONALE FOR THE STUDY

In trying to better understand the factors associated with hospital readmission in order to prevent it, most research studies have used quantitative approaches to answer their questions, often involving psychiatric testing of patients or assessments by professionals. Davidson et al. (1997) argue "conventional approaches to

research...provide yet one more source of the loss of self, unwittingly undermining rather than promoting recovery by treating the person with the disorder as a passive object to be investigated and acted upon by others “ (p.769). Herman (1993, p. 296) states that “there is a dearth of ethnographically-based studies dealing with the post-hospital lives of ex-psychiatric patients...Little systematic attention has been given to ex-patients’ perceptions of mental illness, ...the numerous problems they face on the outside.”

The few studies that have been done that have involved patient perception have focused primarily on patients who have been discharged from state hospitals following extended periods of inpatient treatment (Davidson, Hoge, Merrill, Rakfeldt, & Griffith, 1995). Since most hospital admissions now involve short-term lengths of stay in inpatient treatment, it is important to understand patient perception of the process of achieving mental health both during and after hospitalization.

Relapse prevention programs are based on the assumption that people who are educated about relapse prevention have the ability to keep themselves from relapsing. These programs assume that rehospitalization occurs because patients relapse (Davidson et al., 1997). At Carilion Roanoke Memorial Rehabilitation Hospital the majority of persons admitted to the hospital come voluntarily, particularly if they are being readmitted. They stay for a very brief period of time, with the average length of stay being five days or less. They participate in a program designed to help them recognize and know what to do about relapse, again with the assumption that they are able to do something about preventing relapse. Yet there is little academic research that seeks to understand whether or not the patient perceives himself to be capable of preventing relapse. It was my assumption that patients who accept the concepts of a relapse

prevention plan, perceive themselves capable of preventing relapse, and desire to do so would be active participants in their therapeutic treatment plan. They essentially would assume responsibility for the management of their own mental health. They would self-determine when they needed hospitalization based on their own perception of their mental health status or on the perception of those they trust, such as family members, friends, therapists or psychiatrists. Therefore in implementing a program which relied on patients to manage their own progress in mental health, it was crucial to understand from the patients' perspective whether or not they saw themselves capable of and effective at managing their own mental health, what influenced the continued formation of that self perception, such as their relationships with significant others, when they relied on the perception of significant others versus their own perception, and what challenges they faced that interfered with their ability to prevent relapse.

Since the relapse prevention program implemented at Carilion Roanoke Memorial Rehab was based on principles of relapse prevention historically associated with chemical dependency, it was important to understand how effective these principles have been for persons with mental health problems other than chemical dependency. Since managed care continues to emphasize short term hospital stays, and since the lives of short term inpatient private hospital patients may differ significantly from the lives of patients who have experienced extended-stays in state hospitals, it was important to build on the current available research with a study more specifically geared to understanding the needs of short term hospital patients, such as those who are admitted to the Carilion Roanoke Memorial Hospital Rehabilitation Center.

RESEARCHER'S STANCE

I have always been intrigued by the concept of what helps people create and sustain change in their lives. In recent years I have worked in an inpatient psychiatric unit dedicating my work to helping people create change through various methods, particularly empowerment. Working in this unit, I have been continually challenged to refine my own views of mental illness and mental health: what causes illness, what exacerbates it, and what promotes health. As a professional social worker, the basis of my work is founded in the belief that work with clients starts with a deep respect for them as human beings, which includes working with clients as joint participants in the process of their change. It is the clients themselves who provide the foundational information upon which change is built, and it is the clients themselves who must ultimately do the work of change. As an agent of change, it is my role to seek and process any information which will be helpful in creating change and to work with the client to develop a plan of action to generate change. As a marriage and family therapist I look at the world systemically and see relationships as a primary factor in mental illness and mental health. Even in individual work with a client, I conceive of the client as in relationship to self. As a Christian, I have a strong foundation emphasizing the importance of belief systems in one's ability to function. I find correlates of my religious theology in cognitive behavioral theory and other similar theories.

Given these backgrounds, it was of primary importance to me to include the voice of clients in any research relating to clients, as I saw the information they provided essential to truly understanding how to promote healing. My work with clients has strengthened my belief that the way they perceive the world, others, and themselves, has

a tremendous impact on their potential to volitionally create change. Consequently, it was my desire to do a qualitative study to include the voice of these clients in any research that has as its goal the evaluation and design of therapeutic techniques to enhance client functioning. I wanted to understand the experiences that patients go through once they are discharged from the hospital, how they interpret those experiences, and what has helped them to maintain mental health in the community or to relapse requiring rehospitalization, with a specific emphasis on how the relapse prevention principles taught in the hospital have helped them.

Since a general goal of hospitalization is to promote mental health, I wanted to understand how patients see themselves once they leave the hospital, how they define their current needs in the community, and what they believe the hospital could have done to improve their ability to meet those needs once they have been discharged. It was my hope that the information obtained from this study would enable us to revise our clinical program to better accommodate the needs of our patients through our work with them individually, in groups, and in family meetings.

Relapse prevention principles consistently emphasize the importance of establishing a support system upon discharge. Understanding how family members and significant others serve to promote or hinder mental health functioning in discharged patients and how patients access or block the support of families and significant others may better help us define issues which need to be dealt with in our work with patients, their families, and significant others. My research questions and methodology were based on my personal experience, my professional background in social work and marriage and family therapy, and my theological and theoretical perspectives.

RESEARCH QUESTIONS

What experiences do persons who have been discharged from the hospital go through?

How do they interpret these experiences, particularly with regard to their own mental health and their ability to maintain it?

Do persons who have been discharged from the hospital see themselves as capable of preventing relapse?

How have persons discharged from the hospital managed their mental health?

What do they believe would be helpful in enabling them to continue to improve in their mental health after discharge from the hospital?

What roles do family members and significant others play in relapse prevention?

CHAPTER II

REVIEW OF THE LITERATURE

THEORETICAL FRAMEWORKS

Self-Efficacy

A research focus on relapse prevention, which starts with the voices of clients ascertaining their perceptions of their own mental health and what promotes it, is based on several important theories. Central to the issue of whether clients believe they have the ability to create change in their lives is a theory of self-efficacy, which is grounded in social cognitive learning theory. Perceived self-efficacy is the “belief in one’s capabilities to organize and execute the courses of action required to produce given attainments.” (Bandura, 1997, p. 3) Self-efficacy beliefs determine what goals people choose to pursue, the amount of effort people exert to achieve those goals, how long they persevere in attaining those goals in spite of obstacles and failures, how resilient they are in the midst of adversity, whether their thought patterns help or hinder them, how much stress and depression they endure, and the level of achievement they accomplish (Bandura). Self-efficacy theory postulates that people can regulate their own level of motivation and the subsequent actions they pursue, thus developing the skills they need to increase a sense of self-efficacy. Self-efficacy is the key determinant of human agency, which is the “power to originate actions for given purposes” (Bandura, p.3). Internal factors, consisting of cognitive, affective, and biological events; behavior; and environmental events operate together in triadic reciprocal causation to influence human agency by determining what actions are chosen. Examples of internal factors would include personal aspirations, outcome expectations, perceived opportunity structures and

constraints, conceptions of personal efficacy, well-defined visions of possible selves, and interpretations of one's emotions and physical health.

How a person interprets the internal, behavioral, and environmental events in his or her life both determines and is influenced by the level of self-efficacy that person has. Persons who have high self-efficacy coupled with a perception of a responsive environment that rewards achievement efforts exercise much personal control through self-development. Persons may have high self-efficacy but see the environment as unresponsive and they therefore expect negative outcomes. High self-efficacy with disincentives may result in persons choosing not to exercise agency. Similarly, high self-efficacy without appropriate resources to perform actions results in nonperformance. Persons with low self-efficacy who perceive that their environment is unresponsive become apathetic and do not try to create change. Persons who see themselves as ineffectual but see others as effectual are more likely to become depressed.

Some doubt about one's self-efficacy can motivate a person to acquire the necessary knowledge and skills to function effectively, but in order to initiate and sustain the effort to succeed in difficult tasks, high self-efficacy is required. Self-efficacy is developed and altered by direct mastery experiences, vicarious experiences of mastery through observing similar persons modeling successful performance or verbalizing self-confidence, social evaluations by significant others with expressed faith in a person's capabilities increasing self-efficacy and doubts decreasing it, and changes in physiological states or how they are construed (i.e. a negative mood activates memories of past failures, diminishing a sense of personal efficacy; whereas a positive mood activates memories of past successes, enhancing personal efficacy.)

It is not the direct mastery experience itself that increases self-efficacy, but rather the information that the performance conveys about capability that increases self-efficacy. Since how people view themselves influences how they interpret new information about their capabilities, changing self-perception requires explicit, compelling feedback that forcefully disputes one's pre-existing beliefs. The self-development of efficacy involves much work, responsibility, and risk. People are motivated to engage in the work of developing self-efficacy and exercising self-control by the benefits they believe they will gain from them. If they have positive expectations of physical, social, or self-evaluation effects they have incentive to exercise personal control. Negative expectations are disincentives. People tend to relinquish personal control and depend instead on proxy control ("trying to get others who wield influence and power to act on their behalf", Bandura, p. 17) when they have a low sense of self-efficacy (Bandura).

The relapse prevention program at Carilion Roanoke Memorial Rehabilitation Center is based on the assumption that patients are active participants in their treatment and do have the ability to contribute to their own recovery and prevent relapse. Patients who are depressed, however, often see themselves as helpless and hopeless. Many do not see themselves as capable of creating change, and often express the discouragement that when they know what they ought to do they cannot make themselves do it. From a theoretical perspective of self-efficacy, it was important to understand from the patients who were discharged not only what level of self-efficacy they saw themselves as having, but also how their self-efficacy changed during hospitalization and after discharge and what conditions promoted increased self-efficacy. It was important to understand how

their views of themselves and their environment affected their concepts of self-efficacy, what goals they had for themselves and their expectations of reaching them, what resources and problems they encountered, how they interpreted their emotional and physical symptoms, and how their behaviors influenced their sense of self-efficacy. While in the hospital and once discharged, what experiences of direct mastery or vicarious experiences of mastery affected patients' self-efficacy? How did relationships with families and significant others affect their self-efficacy? How do patients believe their sense of self-efficacy affects their sense of well-being and their progress in recovery from their illness?

Narrative Theory

Patients do not exist in a vacuum. They develop and exist within an interacting system of relationships: with themselves, with family, with non-family members, with their environment, and with their culture. A theory of family therapy that is particularly relevant to a follow-up study of mental health patients existing within a system of interacting relationships is narrative theory. Based on the philosophies of postmodernism and social constructionism, narrative theory was first outlined by Michael White, who was influenced by the writings of Gregory Bateson and Michael Foucault (Gladding, S., 1998; Nichols, M & Schwartz, R., 1995). White views people's problems as related to the stories they have about themselves, their relationships, and their world that give a sense of meaning to their world. When people's dominant stories about themselves, often influenced by cultural narratives, impoverish them, making them feel powerless, it is the goal of narrative therapy to empower clients, by helping them develop alternative stories about their lives that have preferred outcomes. White accomplishes

this by helping families externalize a problem so that they no longer see the problem as residing in themselves. He then seeks to understand the influence of the problem on the client and family and the influence of the client and family on the problem (Gladding). The underlying issue is one of control (Nichols and Schwartz). Through looking for the alternative story that develops White is deconstructing the old unhelpful dominant story and helping clients reauthor new stories. Therapy is collaborative, respectful, and nonhierarchical (Laird, J. 1998). It is done through questions designed to help clients understand that they are separate from their problems and are not themselves the problem, that they have power over their problems, and that they are not who they thought they were.

White sees dominant stories as consisting of not only personal self-narratives but also cultural narratives. Just as personal self-narratives can be self-defeating, so can cultural narratives. When the cultural narratives become oppressive, it is the responsibility of the therapist to help clients author and tell their stories in ways that validate their own experiences and enable them to reconnect with their communities (Laird).

Primarily associated with social constructionism, Karl Tomm has contributed to narrative theory through his typology of interacting patterns and his concept of internalized communities. He labels the interaction patterns between persons as patterns that promote pathology, healing or wellness. An example of a pathologizing interpersonal pattern would be acts of dominance and control coupled with acts of submission and compliance. A healing interpersonal pattern would be a pattern of protesting a dominant interaction coupled with a response of listening and acknowledging

injustice. A wellness interpersonal pattern would be an egalitarian pattern of mutual affirmation and respect. It is the goal of the therapist to externalize these pathologizing interpersonal patterns and initiate a transforming interpersonal pattern with a client through eliciting alternative experiences of a client (Tomm, K. and MacCormack, T., 1998). Although Tomm does not appear to use the term “stories”, his interaction patterns could be seen as the foundation blocks from which clients make meaning of their lives and develop stories about themselves, others, and their world.

Tomm views the individual self as composed of an internalized community, which consists of all the individuals a person has had some sort of relationship with and all their conversations (Tomm and MacCormack). His thoughts about an internalized community are one way to access dominant and preferred stories authored by others that clients carry within themselves.

Narrative theory is particularly suited for understanding the dilemmas of mental health clients. Every client who comes to the hospital has a story about himself or herself. If they do not already come with one, during the course of their hospitalization these clients are given a diagnosis, which is a cultural story about their condition. Although this cultural story may be helpful to the staff in determining treatment methodology, it may or may not be helpful to a client. If staff has not listened sufficiently to a client’s story, they may develop an insufficient treatment methodology, or because treatment is not a precise scientific prescription, staff may have to experiment with various treatment methodologies to determine which one is the most helpful. In the course of this practice of treatment, clients develop stories about themselves as patients. Many have difficulty accepting the constraints of a diagnosis and the particular treatment

used to respond to the diagnosis. They may reject the dominant story of the mental health profession offered to them, which may limit their ability to access important help. Other clients not only accept the dominant story, but also let that story define them so completely that they become subjected to the story, empowering the diagnosis with their identity, and limiting their ability to change because they see themselves as their diagnosis. Still other clients accept what is helpful of the offered dominant story and use it to work on developing alternative stories about themselves promoting wellness.

Clients often enter the hospital overwhelmed by dominant stories that have left them seeing themselves as overwhelmed, powerless, and hopeless, usually with very little self-esteem. Sometimes they have created these stories themselves through repeated patterns of failure in dealing with their world (i.e. alcoholism, substance abuse, divorce, betrayal), yet no story is strictly an individual story but is composed of not only the client's self-perceptions but of the stories of the internalized community which contribute to the pathologizing dominant story. Often these stories were not created by the client, but were originally given to the client by others with pathologizing stories (sexual abuse, physical abuse, emotional abuse, predictions of failure, rejection, etc.). How clients respond to those pathologizing stories determines their current needs in the hospital.

In addition to the above stories, clients often struggle with the cultural stories that are implicit in the lack of availability of resources to help them. Clients who are discharged from the hospital may find themselves unable to access what they need to help them change their circumstances (i.e. inability to afford prescribed medications, inability to obtain disability insurance when they are temporarily unable to work, etc.)

Implicit in a theory of narration which focuses on the issue of the power of dominant stories is a goal of empowerment. Self-efficacy, which measures a belief in one's ability to create change, and depression, which often includes feelings of helplessness and hopelessness, both deal with issues of empowerment. Relapse prevention is essentially a method of empowering patients to manage their own mental health issues. Consequently the evaluation of the effectiveness of a relapse prevention program used a narrative approach to consider how patients have altered their dominant stories and what new alternative stories they have developed about themselves, others, and their world. It sought to understand the processes that enabled clients to accept, reject, or alter dominant stories and create alternative stories. It considered how clients enacted these new stories in their lived experience and therefore how they influenced the problem. It considered how their relationships with family, nonfamily members, their environment, and their culture either supported or hindered the development and living out of these new alternative stories.

Theories of Depression

Since many of the patients at the Carilion Roanoke Memorial Hospital Rehabilitation Center have a diagnosis of depression, it was important to understand the theories of depression that undergird this study, and to perceive how these theories are related to the previously mentioned theories of self-efficacy and narrative theory. The most popular treatments for depression remain cognitive behavioral in approach, and are founded in various cognitive theories of depression. They focus on the different aspects of cognition: the automatic thoughts, the maladaptive assumptions, and the negative schemas that characterize depression (Leahy and Holland, 1999). Albert Ellis, one of the

founders of cognitive theory, developed his irrational beliefs model in 1962, which linked errors in thinking with the subsequent onset of emotional distress (Ingram, Miranda, & Segal, 1998). Ellis' model evolved to become rational-emotive behavioral theory, which proposes that irrational beliefs lead to psychological disorders. Ellis believes depressed individuals hold overly rigid standards by which they judge their own performance, the performance of others, and life happenings in general. Unrealistic expectations lead to disappointment and depression (Ingram et al.) This theory appears to be very similar to Person's theory of maladaptive assumptions, which proposes that individuals who accept maladaptive assumptions (rigid, punitive, and extremely difficult rules or guiding principles that underlie automatic thoughts), such as "should" or "must" statements, are vulnerable to depression whenever they fall short of their expectations (Leahy and Holland).

Aaron Beck was also one of the major founders of cognitive behavioral theories of depression. Beck believed a depressed individual suffered from a negative view of self, experience and the future, which was supported by automatic negative thoughts. Beck clustered individual negative thoughts into negative schemas, or core beliefs about the self. In order for depression to improve, not only must the automatic thoughts be challenged, but also the underlying negative schemas about the self must be changed. This involves not only challenging negative cognitions, but also changing the behavior, which challenges negative schemas (Leahy and Holland).

Another major contributor to theories of depression was Seligman (Leahy and Holland, 1999), who developed the learned helplessness theory of depression, which stated that depression-prone individuals believe that they are helpless to control aversive

outcomes, and thus behave in ways that are consistent with these expectations. Later this theory was revised to include the concept of “attributions”, or patterns of explanations that individuals make for their failures. Depression occurs when individuals attribute failure to internal-stable qualities, such as lack of ability, rather than to internal, unstable qualities, such as lack of effort; or it occurs when individuals attribute positive events to external, unstable events or qualities rather than to internal stable qualities. Abrahamson, Metalsky, and Alloy refined the helplessness theory of depression and developed the hopelessness theory of depression, which attributes the cause of depression to the belief that highly desired outcomes will not occur whereas highly aversive outcomes will occur no matter what one does to try to prevent them (Ingram et al. 1998).

Other cognitive theories that have been influential in understanding depression include the theories that examine the role of self-focused attention: a focus on internal perceptual events or a heightened awareness of one’s behavior or characteristics. One such theory suggests that when individuals experience a disruption in a major life-domain associated with self-worth, they increase their self-focus and subsequently self-evaluation, affecting their self-esteem (Ingram et al., 1998).

Most of the theories of depression have looked at causality of depression. Nolen-Hoeksema has developed a theory of depression that examines rumination as a means of maintaining depression. She proposes that persons who ruminate on depressive symptoms and their causes are more likely to maintain depression than persons who distract themselves (Ingram et al., 1998).

In addition to the cognitive theoretical models of depression, there are several behavioral models, which view depression as a result of a loss, decrease, or absence of rewards. This may entail a loss of rewards from behavior that was once rewarding. Lewinsohn (Leahy and Holland, 1999) developed a theory that understood depression as the result of passive, repetitious, unrewarding behavior. Coyne (Leahy and Holland) expanded that theory to an interpersonal reward model, which hypothesized that depressed individuals initially receive positive reinforcement for complaining, self-preoccupied behavior, however over time they are rejected by others for such behavior, increasing their depression. D’Zurilla (Leahy and Holland) defined depression as resulting from a lack of problem-solving skills that contributed to ongoing feelings of helplessness. He focused on teaching patients to solve problems rather than complaining. Rehm developed the self-control theory of depression based on Bandura’s ideas that behavior is often best maintained by the use of self-reward. Rehm proposed that depression is the result of lack of skills in self-direction of self-reward (Leahy and Holland, 1999).

Another theory of depression that has received much attention in recent years is the interpersonal theory of depression, developed by Klerman and associates (Leahy and Holland, 1999) and based on Harry Stack Sullivan’s social-psychodynamic model of psychopathology. The interpersonal theory of depression defines depression as the result of dysfunctions in interpersonal relationships, such as interpersonal conflict and termination of valued relationships. These problems could be founded in previous relationships, such as parent-child relationships, or current relationships, such as marital or familial (Leahy and Holland).

There are common themes that connect most of the theories of depression with a theory of self-efficacy and narrative theory. Depression theories which emphasize learned helplessness, hopelessness, decreased ability to self-reward, and negative internal stable qualities, relate to perceived self-efficacy, or one's belief in one's capability to organize and execute courses of action required to reach one's goals. Persons who see themselves as helpless and hopeless, who attribute these qualities to permanent characteristics, and who do not know how to motivate themselves through self-reward have low self-efficacy. Depression theories that emphasize negative core beliefs and consequently negative automatic thoughts and maladaptive assumptions, interpersonal relationship problems, and unrealistic standards of judgment for self and the world relate to a narrative theory, which seeks to understand how stories of the self and of families and the world mutually define and shape each other. The issues for research were similar. How did persons who express helplessness or hopelessness redefine their abilities while they were hospitalized and how has that redefinition been influenced by their experiences once discharged? What capacity did persons who do not reward themselves develop while hospitalized to engage in self-reward, and how was that furthered or hindered by their experience in the world? What enabled persons who have defined themselves in terms of negative internal stable qualities to change their self-identity and how was that new self-identity reinforced or reshaped by their post-discharge experiences? How did persons who have negative core beliefs about the world and themselves change those negative core beliefs through hospitalization and subsequent outpatient experiences? How did persons who have interpersonal relationship problems view those problems and change them because of their hospitalization experiences, and

how was that perception affected by discharge experiences? In all these questions, the overriding issue became: how does a hospital program that emphasizes relapse prevention influence a person's perception of self-efficacy both during hospitalization and after discharge?

REVIEW OF RESEARCH

Research on Rehospitalization

Much of the research on rehospitalization has been quantitative research that has examined data on patients who have chronic mental illnesses, often schizophrenia, who have been residents of state hospitals. Speculation about factors associated with readmission has led researchers to examine a wide variety of factors. Frequent general categories examined include service delivery characteristics such as length of stay and receipt of aftercare, client characteristics, and community support (Appleby, Desai, Luchins, Gibbons, & Hedeker, 1993; Appleby, et al., 1996; Davidson, Stayner, Lambert, Smith, & Sledge, 1997; Haywood, et al, 1995; Kent, Fogarty, & Yellowlees, 1995; Klinkenberg and Calsyn, 1996; Lyons, et al., 1997; Mesch and Fishman, 1994; Owen, Rutherford, Jones, Tennant, & Smallman, 1997; Spiegel and Wissler, 1986; Thomas, et al., 1996).

In a review of 72 articles of heavy service users of psychiatric services, Kent, Fogarty and Yellowlees (1995) found a general agreement in the literature that the structure of the service delivery system, the policies of administrators, and the practices of treating staff could be major determinants of heavy service use patterns. Earlier studies focused on inpatient services, and associated brief hospitalizations with insufficient discharge planning and subsequent rapid readmissions (Kent et al.) Byers

and Cohen (1979) looked at pre-hospital, in-hospital, and post-hospital factors in predicting patient outcomes and readmission. The variables with the greatest significance in predicting recidivism were the in-hospital variables of total time hospitalized, number of readmissions, length of stay, and voluntary or detained status at admission. Later studies began to question the validity of using length of stay as a determinant for readmission. Appleby et al. (1993) noted that research studies of smaller populations have generally concluded that length of stay and readmission are unrelated, whereas large scale studies have tended to find that shorter hospital stays are associated with high return rates. In their longitudinal large scale study of patients with a diagnosis of schizophrenia from public hospitals they determined that patients with schizophrenia hospitalized for shorter stays (less than 15 days) were more likely to return within 30 days after discharge; however, over time the percentage difference between relapse among patients with shorter stays and those with longer stays lessened. Appleby et al. (1996) continued to research effect of length of stay and again found evidence that some patients with chronic schizophrenia who experience brief hospital stays are at greater risk of rapid rehospitalization. Thomas et al. (1996) based their research on a private psychiatric hospital program with an average length of stay of 6.2 days down from 21.2 days in 1985. They discovered that overall decreasing length of stay did not result in an increase in recidivism; however, they also discovered that a decreased inpatient length of stay for patients with psychotic disorders might be associated with an increased readmission rate. Lieberman et al. (1998) conducted their research on patients with depression from a private university affiliated hospital. They found no difference in readmission rates for brief stay patients from those who stayed longer; however, they discovered that depressed

patients with shorter lengths of stay show higher levels of depressive symptoms and lower levels of functioning. Some studies associate lower levels of functioning with increased recidivism (Faravelli, C. Ambonetti, A., Pallanti, S. & Pazzagli, A., 1986; Klinkenberg and Calsyn, 1996).

Lyons et al. (1997) in their research questioned whether readmission was a valid indicator of inpatient quality of care. Their study was based on research in private psychiatric hospitals, where the average length of stay was 6.7 days and where the percentage of patients with schizophrenia was only 3.3%, with patients with a primary diagnosis of a major affective disorder predominating at 63.5%. They found that readmission status was not significantly related to length of stay after they controlled for various dimensions of severity of illness. Patients with higher levels of impairment in self-care, with severity of symptoms, and with residential instability were at greater risk of readmission. Impairment in self-care was the only factor significantly associated with 30-day readmissions, although there was a nonsignificant tendency for patients with a higher level of medical complications to be readmitted within 30 days. Patients with higher levels of severity of symptoms, less family involvement, and a tendency to have substance abuse problems were at greater risk of readmission within 6 months. Patients who were suicidal were at lower risk for readmission. Lyons et al. found that substance abuse problems did not predict readmission, however, they speculated that referral to outpatient treatment may have been a significant factor in prevention of relapse, since other studies based on public psychiatric hospitals have consistently shown that coexisting substance related disorders do predict readmission.

Lyons et al. (1997) speculated that readmission was more a reflection of quality of community services or support than of hospital quality of care. In their review of research on aftercare, Klinkenberg and Calsyn (1996) found that an initial contact with aftercare services has been consistently associated with lower recidivism rates. Service delivery characteristics promoting easier and quicker access to aftercare, such as making appointments for clients, contacting clients before their appointment, scheduling appointments within two weeks after discharge, were positively related to receipt of aftercare. In addition, provision of medication has been positively associated with receipt of aftercare. Other studies focusing on community treatment have discovered that assertive and intensive case management programs in the community significantly reduced frequency of crises, hospital readmissions and length of stay, and increased rates of treatment compliance (Frazier, R. S. and Casper, E. S. 1998; Kent et al., 1995; Klinkenberg and Calsyn, 1996). Wan and Ozcan (1991) examined public hospital readmission rates in the state of Virginia and analyzed receipt of aftercare through the public mental health system. Contrary to expectation, they discovered that the community service boards offering more services had higher readmission rates. This led them to question the adequacy of community service boards in preventing rehospitalization; however, another interpretation could be that readmission is a reflection of the course of mental illness itself, with disorders varying in their severity, duration of episodes, and time between episodes (Fisher, W. H., Geller, J. L., Altaffer, F., & Bennett, M. B., 1992; Lyons et al., 1997). In Australia Owen et al. (1997) examined the relationship between rehospitalization and type of psychiatric aftercare. They discovered that rehospitalized patients received more aftercare than nonrehospitalized patients;

however, the type of aftercare they received was crisis-oriented. Rather than receiving private psychiatric hours or intensive case management, they received more emergency department hours, more family physician hours, and more mobile treatment team hours.

Client characteristics are another major category of variables examined as influences on rehospitalization. Demographic variables such as gender, race, age, marital status, and educational level have shown no consistent relationship to recidivism (Klinkenberg and Calsyn, 1996; Kent et al., 1995, Owen, et al., 1997). Occupation has also had inconsistent results; however several studies do relate occupation to rehospitalization with patients with greater social competence in handling work situations having decreased likelihood of rehospitalization (Erikson and Paige, 1973; Mesch and Fishman, 1994). Several studies have noted that involvement in leisure activities decreases the likelihood of rehospitalization (Avison and Speechley, Klinkenberg and Calsyn). Patient dissatisfaction with finances has been found to be a significant risk factor for readmission (Owen, et al, 1997). Haywood et al. (1995) found no significant relationship between rehospitalization and housing problems, family problems, or money problems; however, their results differed from other studies, and they speculated that the results were influenced by their population of state hospital patients. Other studies have found a significant relationship between poor housing and poor community adjustment outcomes (Baker and Douglas, 1990; Erickson and Paige, 1973). Alcohol and drug problems have been associated with increasingly more frequent readmissions (Haywood et al.; Sullivan, Wells, Morgenstern, & Leake, 1995). One specific type of patient with a consistent characteristic of substance abuse problems who has increased rehospitalization rates is the patient who leaves the hospital against medical advice (Pages et al., 1998).

Noncompliance with medication regimens has also been found to have a significant effect on rehospitalization with one study attributing 50% of all psychiatric rehospitalizations to medication noncompliance (Haywood et al.; Klinkenberg and Calsyn; McFarlane et al, 1995, Sullivan et al.).

In addition to the above factors, the number of previous admissions has been shown to be associated with rehospitalization (Appleby et al., 1993; Avison and Speechley, 1987; Kent et al., 1995; Klinkenberg and Calsyn, 1996). The association of diagnosis with recidivism has been inconsistent. Some studies linked a diagnosis of schizophrenia with increased chances of recidivism (Kent et al., 1995; Klinkenberg and Calsyn; Sanguineti, Samuel, Schwartz, & Robeson, 1996), and noted that schizophrenic illnesses and major mood disorders were the most common diagnoses among heavy users of psychiatric services (Hadley, Culhane, & McGurrin, 1992). Some studies correlated severe personality disorders with high recidivism (Reich and Green, 1991). Adjustment disorder was one diagnosis that was associated with fewer rehospitalizations (Greenberg, Rosenfeld, & Ortega, 1995). Most studies, however, reported no association between diagnosis and recidivism (Klinkenberg and Calsyn). Instead of diagnosis, some studies focused on specific psychiatric symptoms and level of functioning. Studies that used a single global rating of functioning found no relationship with recidivism (Klinkenberg and Calsyn); however, studies which used specific symptoms identified a high association with recidivism, such as symptoms reflecting a danger to self or others, not being friendly with others, being angry and breaking things, and isolating from family members (Klinkenberg and Calsyn).

The third major category of variables examined as influences on rehospitalization was community support, which includes an individual's living situation and the support provided by family and other informal sources. Research on living situation and rehospitalization has revealed varied results. Some studies showed no relationship; however, others documented that patients who live with their parents have the highest rate of recidivism, whereas those who live with their family of procreation have the lowest rate. In between are those who live alone (Klinkenberg and Calsyn, 1996; Mesch, 1994). Homelessness is clearly connected to mental health problems; however the link between homelessness and recidivism has not yet been clearly established (Kent et al., 1995).

Type and quality of family relationships was another significant factor affecting rehospitalization. Patients who experienced a high level of expressed emotion (generally defined as overly involved and critical) and a higher percentage of conflictual relationships in their support network have been identified to be at greater risk of rehospitalization, as have patients with smaller social networks (Avison and Speechley, 1987; Klinkenberg and Calsyn, 1996; Spiegel and Wissler, 1986; Sullivan et al, 1995)

In summary, quantitative research studies on rehospitalization have provided a rich resource of data identifying several factors associated with rehospitalization. Among the most common factors were service delivery characteristics, including length of stay and receipt of aftercare; client characteristics, such as medication compliance and severity of symptoms; and community support, such as family relationships. Because relapse prevention is so strongly associated with research on rehospitalization in the

literature, it was important to include that research; however the few qualitative studies interviewing patients on rehospitalization revealed a completely different picture.

Davidson et al. (1997) interviewed 12 recidivist patients to obtain descriptions of their experiences of rehospitalization, the circumstances surrounding rehospitalization, and the functions it served for them. They discovered that patients did not necessarily view rehospitalization as a circumstance to prevent, but rather viewed the hospital as an attractive place they appreciated being able to return to as needed. Positive attributes of rehospitalization included safety, respite, food, and privacy, and a sense of being cared for. Rehospitalization was often described as a “vacation”, with the most important characteristic being that “there are lots of people to listen to you” (1997, p. 774).

Over time rehospitalization became “like coming home again” (1997, p. 774.) In stark contrast, rehospitalization was compared to community living as: “...hiding away. Where I live it’s intercity, so I felt that I had a better chance living here than living in society” (1997, p. 775). Community living was noted for its absence of caring and social isolation.

Understanding rehospitalization was an essential component of understanding what promoted relapse prevention and what promoted mental health, however in some cases rehospitalization may itself be more an indicator of client success in choosing rehospitalization in order to promote mental health rather than an indicator of clinical failure (Sylvester and Bean, 1989). To further understand what promoted mental health, I next considered the research on relapse prevention.

Research on Relapse Prevention

Much of the current work on relapse prevention was based on a relapse prevention model proposed by Marlatt and Gordon (Larimer, Palmer, & Marlatt, 1999). Marlatt and Gordon identified both immediate determinants of relapse (high risk situations such as negative emotional states, interpersonal conflict, social pressure, and positive emotional states; coping skills; outcome expectancies; and the abstinence violation effect) and covert antecedents (apparently irrelevant decisions, lifestyle imbalances, and urges and cravings) as contributors to relapse. They designed specific intervention strategies (identifying personal high-risk situations, identifying personal warning signs of relapse, evaluating motivation and ability to cope, increasing effective coping skills, enhancing self-efficacy, countering misperceptions about the benefits of alcohol, developing lapse-management strategies, and cognitive restructuring) to help clients prevent relapse. They also emphasized global lifestyle self-control strategies (balanced lifestyle with positive addictions, stimulus-control techniques, urge-management techniques, and relapse road maps) for the same purpose.

Since the development of Marlatt and Gordon's model several reviews of research have examined the effectiveness of treatments in preventing substance abuse relapse based on their model (Carroll, 1996, Irwin et al. 1999). Carroll (1996) reviewed research comparing the effectiveness of relapse prevention with no treatment and found significant effects favoring relapse prevention post treatment and at one year follow-up. Studies that compared relapse prevention to attention controls and standard treatment showed mixed results post treatment with relapse prevention being significantly more effective in only about one-half of the studies. Follow-up findings revealed a more effective picture with

7 of 11 studies indicating sustained effects, continuing improvement, or less relapse associated with relapse prevention. Studies that compared relapse prevention treatment with alternate psychotherapeutic treatments found no significant difference between treatments either at post treatment or follow-up. Carroll (1996) found several studies indicated relapse prevention may reduce the intensity of relapse episodes and may result in sustained or continuing improvement over time associated with the implementation of generalizable coping skills conferred through relapse prevention treatment.

Irwin et al (1999) conducted a meta-analysis of 26 studies to determine the overall effectiveness of relapse prevention and the extent to which certain variables were related to outcome. They found that relapse prevention was significantly more effective in treating alcohol and polysubstance use than in treating smoking or cocaine use. They found no significant differences in effectiveness between inpatient and outpatient settings, between individual or group modalities. Conjoint marital therapy using relapse prevention was shown to be particularly effective, but the findings were based on only two studies and therefore have to be interpreted with caution. Later research by some of the authors of one of those two studies (O'Farrell et al, 1996) found relapse prevention treatment as part of conjoint marital therapy to be more effective in preventing relapse than regular conjoint marital therapy. Irwin et al found medication may contribute substantially to enhancing treatment effectiveness, particularly for alcohol problems. Interestingly, they found relapse prevention appeared to have more impact in improving psychosocial functioning (i.e. clients' ratings of the severity of their problem, marital adjustment, acquisition of cognitive and behavioral coping and problem-solving skills to

avoid relapse, self-efficacy, locus of control, and depression) than on reducing substance use.

In recent years there has been a subtle change in the field of substance abuse research dealing with relapse prevention issues, as researchers began to question the difference between relapse prevention treatment which focuses on avoiding a negative result and maintaining and sustaining change which focuses on predicting success. An immediate issue in changing focus was defining what is success. Like relapse, success has multiple definitions. In addition to the issue of what constitutes success and how long behavior must be maintained to be considered successful is the issue of who defines success: the clinician, the client, the client's family, the client's employer, etc?

Westerberg (1998) acknowledges the above problems with definition and reviewed the research to determine factors associated with successful outcomes for treatment of addictive behaviors. He noted that clients who have positive rather than avoidant coping skills, who have social support for change, who have expectancies that favor change, who have high self efficacy, and who have greater motivation for change manifested in actively taking steps to overcome their problem, have more favorable outcomes. He concluded that treatment for addictive behaviors should focus on strengthening clients for success rather than placing primary emphasis on avoiding failure and he recommended the following ways to do so: increasing social support for sobriety, promoting experimental methods of change, supporting any actions taken to promote change, rather than focusing on slips and relapses, strengthening self-efficacy by helping a client recognize the connection between previous attempts to change and prior successes, and

addressing a client's general life problems in treatment through enhancing positive coping styles.

Over the years relapse prevention became a concern for patients diagnosed with non-substance abuse mental health diagnoses. Although the term "relapse prevention" implies a similar goal of preventing reoccurrence of the targeted problem for mental health patients as it did for substance abuse patients, the method of relapse prevention is less well defined and often refers to specific types of therapies commonly used to treat mental health patients.

Because one of the factors associated with relapse is noncompliance with medication directives, researchers have focused on ways to improve medication compliance. Azrin and Teichner (1998) developed an instructional program for improving medication compliance for chronically mentally ill outpatients through their community mental health center. They discovered that patients who were given information regarding medication and its benefits had a 73% compliance rate, whereas patients and patients and families given comprehensive guidelines (including filling prescriptions, use of a pill container, transportation, self-reminders, doctor's appointments, etc.) had a medication adherence of 94%. Unfortunately, they did not directly assess the effect of increased medication compliance on prevention of relapse.

Because type and quality of family relationships have been shown to be a factor in rehospitalization, researchers have examined the role of the family in recovery and in preventing relapse. Keitner et al (1995) used subjective ratings of family functioning by patients and family members and objective ratings by clinicians to determine the relationship of family functioning over time to recovery of patients experiencing a major

depressive episode at a university-affiliated hospital. They measured six dimensions of family functioning (problem solving, communication, roles, affective responsiveness, affective involvement, and behavior control) as well as general functioning. Clinician ratings for both good and poor functioning families revealed a pattern of initial improvement in the acute stage of illness followed by a setback in functioning over the 12 months. Self-ratings by families revealed that families that saw themselves as functioning healthily in the initial ratings maintained those ratings, whereas families that initially saw themselves as functioning poorly improved significantly over time. Patients whose families had rated themselves with good family functioning were more likely to recover from their depression within one year than those with poor family functioning.

Friedmann et al (1997) also studied family functioning and mental illness. They discovered that compared to control families without a psychiatric patient, families with a depressed member exhibited higher levels of dysfunction across more dimensions of family functioning than any other psychiatric diagnostic category. Interestingly the three dimensions of family functioning that families with a depressed member scored the highest level of dysfunction on were communication, general functioning, and behavior control.

Johnson (1998) also examined the influence of general family functioning on seriously mentally ill adults; however, his sample included patients with at least one previous hospitalization for a psychotic episode involving a mood or thought disorder and in addition to family functioning, he looked at the influence of family members' sense of competence on the community adaptation of the patients. He discovered that both variables had a significant impact on the ill family member's level of adaptation;

however, sense of competence had the stronger influence and almost half of the total influence of family functioning came from its indirect effect mediated by sense of competence. In a continuation of his study, Johnson interviewed family members of his sample of patients to develop a greater understanding of family's experiences living with a member with mental illness. He discovered that family members often feel disregarded or dismissed as irrelevant by mental health professionals and by psychiatrists. They did not see themselves as part of a treatment team even though they often were expected to fulfill case management functions once a patient was discharged from the hospital. Families reported recognizing early warning signs of decompensation, yet finding professionals rarely heeding the information that they reported. Since relapse prevention stresses the importance of recognizing and responding to early warning signs of relapse, recognition of the family as a potential valuable aide in relapse prevention techniques is an important area to be investigated. In his follow-up study Johnson continued to discover that a family's sense of competence and meaning was an important contributor to both family and ill member's success in the community. He found that families' sense of competence was increased by a feeling that family members were working together on the mental health problems, by an anchoring religious faith, and by connection with self-help support groups.

In 1994 Hiss, Foa, and Kozak conducted research on relapse prevention techniques used with patients with obsessive-compulsive disorder. Using a stringent criterion of 50% improvement over pretreatment functioning as their standard for clinically significant outcome, they found that 75 % of the group receiving relapse

prevention remained improved at follow-up compared with 33% of a group receiving associative therapy. Not only did the relapse prevention group show improvement in obsessive-compulsive symptoms, but they were also significantly less depressed and anxious.

Because the relapse rate for depression 12 months postremission was between 35% and 55%, researchers sought to identify patient characteristics that rendered individuals especially vulnerable to relapse (Illardi, Craighead, & Evans, 1997). Several studies have found a significant relapse risk associated with dysfunctional attitudes, or negativistic beliefs (Illardi et al.) Relapse is also predicted by the number of prior depressive episodes, the presence of double depression, and depression severity rating at posttreatment (Illardi et al.). Illardi et al. in their research found that the presence of Axis II pathology was significantly and substantially associated with relapse, with patients suffering from nonpsychotic major depression who did not have a comorbid personality disorder having an expected remission period 7.4 times longer than patients who suffered from both major depression and an Axis II disorder. In contrast to previous research, Illardi et al. did not find that dysfunctional attitudes or negative event attributions were significantly associated with depressive relapse. In addition to understanding the factors associated with relapse, Illardi et al. examined what promotes relapse prevention by examining the tendency to make internal, stable, and global attributions for positive events and its effect on relapse prevention. They found that for each 1-point increase in the ASQ score measuring positive attributions there was a 6% increase in length of remission, such that an increase in one standard deviation led to a doubling of expected remission time.

Other researchers have also investigated the effect of a tendency to make internal, stable, and global attributions for positive life events on depression. Johnson, Han, Douglas, Johannet, and Russell (1998) discovered that internal, stable, global attributions for recent positive events mediated a significant association between attributional style of positive life events and decreased hopelessness, and decreased hopelessness mediated a significant association between internal, stable, global attributions for recent positive events and decreases in depressive symptoms. Although their research is focused mainly on understanding recovery from depression, I questioned whether those same factors that are instrumental in promoting recovery might not also be instrumental in maintaining recovery and preventing relapse. This is an assumption that I hoped to explore further in my research. The underlying issue is what is recovery and what is the association between those factors that promote recovery and those factors that maintain recovery?

John D. Teasdale focused his research on understanding the role of emotional processing in the prevention of relapse in depression (1999). Based on the work and theory of Jack Rachman, Teasdale used Rachman's definition of emotional processing: "a process whereby emotional disturbances are absorbed and decline to the extent that other experiences and behavior can proceed without disruption." Effective emotional processing occurs when there is a reduction in the response to probes presented which would normally re-evoked an emotional reaction (i.e. depression). Teasdale theorized that individuals who have experienced previous episodes of depression are vulnerable to relapse when the patterns of negative thinking such as globally negative self representations, dysfunctional relations between self worth and approval from others, and

ruminative thought patterns focused on deficiencies of the self and self-blame become activated by dysphoric states.

He called these patterns depressogenic processing cycles, and identified the goal of relapse prevention to be to change the ease of reactivation of the depressogenic processing configuration. He saw emotional processing which changes the emotional responses to internal affective events and thoughts as the method of relapse prevention. In promoting emotional processing, Teasdale proposed using two strategies: a cognitive behavioral therapy which requires clients to perform such exercises as thought identification and results in a shift in mind-set such that thoughts and feelings are no longer “the self” but rather events in the mind to be considered and examined, and a mindfulness-based technique similar to the work of Marsha Linehan’s dialectical behavior therapy that teaches recovered recurrently depressed patients to become more aware of depression-related thoughts and feelings at times of potential relapse. The goal of mindfulness “is to be fully aware of one’s experience in each moment, equally open to whatever it has to offer and free of the domination of habitual, automatic, cognitive routines that are often goal-oriented and, in one form or another, related to wanting things to be other than they are.” (Teasdale)

Teasdale developed his therapy into a mindfulness-based cognitive therapy program (MBCT) that he evaluated in a multicentre, randomized controlled clinical trial involving 145 patients. The results of the trial were that for patients with a history of at least three previous episodes of major depression (77% of total sample), relapse over the 60-week study period was reduced from 66% in patients continuing with treatment to 37% in patients participating in MBCT.

Because cognitive behavioral therapy is the treatment of choice for patients who are experiencing depression, researchers have examined it to determine effectiveness in relapse prevention. Gortner, Gollan, Dobson, and Jacobson (1998) compared the effectiveness of complete cognitive-behavioral therapy for depression in preventing relapse with the use of its two major components: behavioral activation and behavioral activation with automatic thought modification. They expected to find that cognitive-behavioral therapy was the most effective treatment in preventing relapse, but instead they found no significant differences between the three treatments either for short or long-term outcomes. Fava, Rafanelli, Grandi, Canestrari, and Morphy (1998) also examined whether cognitive behavioral treatment of residual symptoms of depression had a significant effect on the relapse rate. They conducted a 6-year follow-up assessment of 40 patients with major depressive disorder who were successfully treated with antidepressants and then randomly assigned to either cognitive behavioral treatment of residual symptoms or standard clinical management. They found no significant difference in relapse (50% vs. 75%); however, when they considered the number of relapses, the cognitive behavioral treatment group was significantly lower in numbers of depressive episodes than the standard clinical management (CM) group. Fava, Rafanelli, Grandi, Conti, and Belluardo (1998) did a two-year follow-up study of the use of CBT for residual symptoms of depression versus the use of CM for patients successfully treated with pharmacotherapy. They defined recurrent depression as greater than 3 episodes of depression. In their population of forty patients they discovered that patients receiving CBT had only a 25% relapse rate as compared to an 80% relapse rate for patients receiving CM.

Fava et al base some of their research on the issues raised by Ryff and Singer (1996), who differentiated between treatment that alleviates depression and brings a person out of negative functioning, and treatment that facilitates progression toward restoration of the positive. Ryff and Singer suggested that the absence of well-being created conditions of vulnerability to relapse. Therefore in their research Fava et al included a CBT strategy that enhanced well-being. In previous research Fava, Rafanelli, Cazzaro, Conti, and Grandi (1998) discovered that well-being therapy, as part of CBT, was significantly more effective in decreasing residual symptoms of depression over standard CBT strategies. Other researchers have also begun to differentiate between being asymptomatic from depressive symptoms and successful adaptation to the community involving feelings of well-being and integration into community activities (Hall and Nelson, 1996). They identify factors affecting well-being as people's perceptions of the availability of support and having a sense of control. Sylvester and Bean (1989) in their qualitative study of 77 state psychiatric hospital patients interviewed 6 months after discharge found that general well-being perceived by the patients was the strongest predictor of community length of stay.

In their qualitative study of patients with schizophrenia who participated in relapse prevention groups Davidson, Stayner, Lambert, Smith, and Sledge (1997) also differentiated between a relapse prevention concept which encouraged patients to minimize and contain the impact of their illness by monitoring for and preventing relapses versus the pursuit of well-being through recovery and community adaptation. In their interviews they discovered that patients felt alone and abandoned in the community and with little or no control over their illness and their lives in general. They did not see

mental health treatment as being useful in helping them deal with the above problems nor did they see any connection between attending outpatient treatment and the prevention of rehospitalization. In response to their initial research, Davidson et al redesigned their relapse prevention program to focus on addressing the social isolation and loneliness patients experienced in the community, and to instill hope through providing evidence of the ability of patients to achieve some mastery over their condition and problems. The preliminary outcome data from the first 6 months of the revised program revealed that readmissions during the first 3 months postdischarge among the first 15 patients to participate were reduced by almost 70% and days spent in the hospital during the same period were reduced by more than 90%.

In summary, research on relapse prevention raises many significant issues such as what is relapse prevention, what is the goal of relapse prevention, how does relapse prevention relate to the maintenance of change and success or how do methods promoting recovery relate to the maintenance of recovery and well-being, what is well-being and how does relapse prevention relate to the promotion of well-being? Research thus far on relapse prevention with patients with substance abuse issues affirms the effectiveness of relapse prevention treatment and recognizes relapse prevention may be particularly effective in reducing the intensity of relapse episodes, in sustaining improvement over time through teaching and helping clients implement general coping skills, and in increasing psychosocial functioning. Relapse prevention for patients with various psychiatric disorders has improved medication compliance, emphasized the importance of healthy functioning family relationships when families have a sense of competence and meaning in preventing relapse, emphasized the importance of positive

support systems, and demonstrated the effectiveness of emotional processing, cognitive behavioral therapy, and the importance of patients having a sense of well-being and high self-efficacy and hope. I next turn to the literature on self-efficacy and depression to further understand variables affecting mental health.

Research on Self-Efficacy and Depression

Research on self-efficacy and depression looks at the influence of levels of self-efficacy through various pathways on development of and maintenance of depression. Bandura demonstrated that low self-efficacy beliefs related to ability to fulfill valued standards and personal aspirations result in self-devaluation and depression (Bandura, 1996). Failure to fulfill valued standards results in high motivation and low despondency when people have high self-efficacy; however, when they have low self-efficacy failure results in decreased motivation and increased depression.

Bandura specifically researched the role of parents in promoting academic efficacy in relation to valued standards and personal aspirations. He discovered that parents who have high parental efficacy (the belief in their ability to exercise influence over their children's development) are more proactive and successful in promoting their children's competencies. Children of parents with high parental efficacy and educational aspirations for their children themselves have higher perceived academic efficacy and aspirations, prosocial orientations, lower depression and problem behaviors, and higher scholastic achievement. Bandura (1999) researched self-efficacy pathways to depression in children and discovered that perceived social and academic inefficacy contributed to a sense of concurrent and subsequent depression both directly and through their impact on

academic achievement, socialization, and problem behaviors. He found that perceived social inefficacy had a greater impact on depression in girls than in boys.

Bandura (1996) also demonstrated that high social efficacy resulted in positive social relationships, whereas perceived social inefficacy resulted in socially alienating behaviors. Social support reduced vulnerability to depression. Holahan and Holahan (1987) discovered that a low sense of social efficacy contributed to depression both directly and by curtailing developing of social supports. McFarlane, Bellissimo, and Norman (1995) examined the role of family and peers in the development of social self-efficacy in adolescents. Their research identified both family and peers as significant sources of the development of social self-efficacy, and family support negatively correlated significantly with depression.

McFarland et al pointed out that the variables associated with depression in adolescents are also associated with depression in adults. Since parental efficacy has been identified as a significant factor in promoting competency in children and adolescents, and family functioning and family sense of competence have also been shown to correlate significantly with patient functioning, I questioned whether a sense of “family efficacy” (family members’ belief in their capacity to assist their family member in attaining mental health) of families dealing with patients with depression could increase family involvement and influence a sense of well-being in patients coping with depression. In addition, were patients whose families supported their social self-efficacy less prone to isolate and withdraw from others, relapsing in depression?

Nolen-Hoeksema (1991) researched factors related to the maintenance of depression and discovered that recurrent ruminations about dejecting life events and

one's despondent state increased and prolonged depressive episodes, whereas engagement in activities that refocused one's attention or improved one's life terminated them. A low sense of self-efficacy to reduce ruminative thoughts contributed to the occurrence of depressive episodes, their length, and their reoccurrence (Kavanagh and Wilson, 1989).

Bandura proposed beginning to explore the impact of emotional self-regulatory efficacy on depression and prosocial behavior. Kavanagh and Wilson's previous research demonstrated that improvement of depression during treatment was closely associated with self-efficacy regarding control of mood and with self-monitoring of levels of negative cognition.

Bandura also raised the issue of the effect of level of self-efficacy not only on the development of depression but on the treatment of depression, since people who are depressed doubt their ability to implement the skills therapists teach them to help reduce depression (Bandura, 1999). Choosing to implement skills learned in therapy involves goal-setting tasks. Phillips and Gully (1997) found that high self-efficacy leads to higher self-set goals and higher performance. This raised the question of whether patients who have low self-efficacy and depression choose lower goals and have resultant lower performance.

Several studies have emphasized the influence of stressful life events on depressive symptoms (Kendler, Thornton, & Prescott, 2001). Maciejewski, Prigerson, and Mazure (2000) studied whether the symptoms of depression undermined self-efficacy, whether stressful life-events undermined self-efficacy, and whether self-efficacy mediated the effect of stressful life events on symptoms of depression. They

differentiated between stressful life events that were independent of an individual's behavior and stressful life events that were at least partly dependent on an individual's behavior. They also differentiated between persons with prior depression and those without prior depression. They found that independent stressful life events had a significant impact on symptoms of depression for those without prior depression but not for those with prior depression. Dependent stressful life events had a significant impact on symptoms of depression both for persons with prior depression and those without prior depression. Dependent stressful life events also had a significant negative impact on self-efficacy for those who had suffered prior depression, but no impact on self-efficacy for those without prior depression. They found that persons with prior depression at baseline had significantly greater numbers of dependent stressful life events, but persons without prior depression did not. They found that higher levels of self-efficacy at baseline resulted in less severe symptoms of depression both for those with prior depression and for those without. They also found that more serious symptoms of depression at baseline significantly predicted poorer self-efficacy at follow-up. Recognizing the importance of theories that uphold causal attributions as significant factors of depression, Maciejewski et al recommended researching the connection between style of causal attributions and self-efficacy in response to dependent stressful life events.

Stajkovic and Sommer (2000) studied the relationship between self-efficacy and causal attributions and performance. They found that individuals high in initial self-efficacy attributed performance success to internal causes and performance failure to external causes. Performance success did not enhance subsequent self-efficacy; however

performance failure did result in decreased self-efficacy. Individuals low in initial self-efficacy attributed performance success to internal causes with resultant increased self-efficacy. Those low in self-efficacy also attributed performance failure to internal causes, with resultant decreased self-efficacy. Although Stajkovic and Sommer were not specifically researching the connection between causal attributions, self-efficacy, and depression, further research specifying these connections would be important. At the Carilion Roanoke Memorial Hospital Rehabilitation Center many of the patients who are depressed express a sense of low self-efficacy. They also often express a sense of self-blame for what they perceive as their failure to handle their problems. It was important to understand how the relapse prevention principles they learned while in the hospital helped build their sense of self-efficacy and decrease their fear of failure, and what influence that had on their depression.

A significant factor in depression is chronic pain. A significant percentage of patients at the Rehabilitation Center who are depressed experience chronic pain. Arnstein, Caudill, Mandle, Norris, and Beasley (1999) conducted research on self-efficacy as a mediator of the relationship between pain intensity, disability, and depression in chronic pain patients. They found that both pain intensity and self-efficacy contributed to the development of depression, with patients with lower self-efficacy who did not believe in their ability to manage their pain, cope, and function, more likely to become disabled and /or depressed. Because pain intensity itself also had a significant effect, they recommended a multifaceted approach to treatment of chronic pain patients.

Muris, Schmidt, Lambrichs, and Meesters (2001) investigated the role of several protective and vulnerability factors in the development of depressive symptoms in

adolescents, suggesting that depression frequently has its onset in adolescence. They found that depression was positively associated with parental rejection, negative attributions, and passive coping, but negatively associated with active coping and perceived high self-efficacy. They developed a model based on their data with negative parental rearing behavior and a negative attributional style as primary sources of depression, and coping styles and self-efficacy providing a mediating role in the formation of depressive symptoms. Although the Carilion Roanoke Memorial Hospital Rehabilitation Center does not accept patients under the age of eighteen, many of our depressed patients have experienced some form of rejection and see themselves as helpless and hopeless to change things. Relapse prevention techniques help patients to understand what they can change in relationships and how to go about it. It was important to understand from patients who were discharged from the program how they felt they were able to influence their relationships after discharge and how this impacted their depression.

Muris, Bogie and Hoogstedler (2001) did an evaluative study of the Resourceful Adolescent Program, a school based early intervention program designed to foster psychological resilience in adolescents. The evaluation revealed significant reduction in anxiety and depression and increase in self-efficacy following program intervention. Many of the interventions are similar to the interventions and skills training emphasized in the Carilion Relapse Prevention Program, however the Resourceful Adolescent Program is outpatient, and occurs over an extended time, versus the Carilion Relapse Prevention Program, which is inpatient and intensive occurring usually in less than a week.

In summary, there has been much research emphasizing the connection between self-efficacy and depression. This research sought to broaden our understanding of that connection by studying the effect of a relapse prevention program on self-efficacy and depression, and how patients were able to implement what they have learned to promote their mental health and well-being post-discharge.

CHAPTER III
METHODOLOGY

QUALITATIVE METHODOLOGY

In a research project focused on understanding issues of self-efficacy and empowerment and how they related to relapse prevention in clients suffering from mental health problems, it was necessary to include the voices of those clients and whenever possible their families and significant others in order to adequately understand how they perceived their process of achieving mental health. Qualitative studies are particularly suited for understanding clients' perspectives of their world and how they interpret what they perceive as well as understanding the context (i.e. such as family environment) in which clients function and how that context influences them and is influenced by them. They are also particularly effective for generating grounded theories about unanticipated influences, for understanding the process by which something happens, and for developing causal explanations (Maxwell, 1996). All of the above factors make qualitative studies particularly suited for evaluative research that has a goal of improving existing programs (Maxwell).

Since the goal of my research was to understand whether participants saw themselves as mentally healthy, what factors participants believed were important in promoting or hindering their mental health, how the relapse prevention principles they learned at Carilion have helped them interact with those factors to obtain and maintain mental health, what role family members and significant others played in relapse prevention, and what participants believed would have been helpful to have learned in the

relapse prevention program that they did not learn in order to improve our existing program; I chose to do a qualitative study.

SAMPLE

The sample of research participants in this study was defined by its purpose and the method was purposeful sampling (Maxwell, 1996). It was based on clients who had been participants in the relapse prevention program at Carilion Roanoke Memorial Hospital Rehabilitation Center, who had participated in at least one three day cycle of the structured relapse prevention program, who had demonstrated an understanding of relapse prevention principles, and developed a personal relapse prevention plan upon discharge as evidenced by the documentation in their medical record. The participants had to have been discharged from the hospital for at least three months but no longer than a year when the research began. That length of time allowed for medication to have reached its maximum effectiveness and sufficient life experiences to have occurred, but also limited the forgetfulness associated with too much passing of time.

In order to obtain as broad a perspective of experiences of clients as possible, adhering to a maximum variation approach, as described in Miles and Huberman (1994), the sample included participants who had not returned to the hospital for readmission and participants who had been rehospitalized. In order to further understand the influence of chronic illness on relapse prevention, the sample included participants with a first time diagnosis and participants who had a history of treatment. Because there is a lack of information on experiences of patients post-discharge from a short-term care facility, and because the majority of patients receiving treatment in a short-term care facility are

struggling with depression, I limited my sample to patients with a diagnosis from that category. I interviewed 10 clients.

My sample was drawn from participants who had filled out patient satisfaction surveys upon discharge from our program. Over the course of nine months I reviewed approximately seven hundred patient satisfaction surveys, separating the ones who agreed to have a follow-up contact with someone from the hospital from those who did not agree. In addition to participants who gave positive ratings of patient satisfaction, I had hoped to interview participants who appeared negative about their experience in the Rehab; however, those participants usually did not agree to have follow-up or did not meet the criteria.

The population who agreed to follow-up was small, compared to the ones who did not agree. From the population who agreed I reviewed approximately seventy-five charts to determine which participants met criteria for contact to invite them to participate in the study. Approximately fifty percent met criteria for participation. In trying to contact patients, I discovered that a significant proportion no longer had current phone numbers as listed in the charts and many had changed addresses. Some patients simply were never at home. Since HIPAA was just being implemented at the time of recruitment, I was concerned about any potential violation of HIPAA and did not pursue researching change of addresses and phone numbers.

All of the participants met the research criteria, however one participant differed from the other participants in that she had a longer hospital stay and was given ECT as a treatment. I thought about whether to include her because of the ECT, since participants with ECT can have occasional short-term memory problems, but decided to include her

as I realized that she still was able to answer the research questions. The following quote is some of my thoughts from my memo about including her:

She still had experiences post-discharge that were important. She still had to implement a relapse prevention program. She had made progress, and the question of why she made progress (i.e. ECT or relapse prevention) is moot: every patient had other factors too (i.e. medication, environmental circumstances, outpatient therapy or lack of outpatient therapy, etc.)

DATA COLLECTION

Prior to the actual implementation of the research study with the participants, I obtained permission and attended two outpatient groups related to relapse prevention as an observer. My goal was to familiarize myself with experiences of persons recovering from an illness from their perspective prior to interviewing. The first outpatient group was an Intensive Outpatient Program offered by Carilion for participants with a history of substance abuse seeking to achieve and maintain abstinence from addictive chemicals. Paid professionals led the group, and part of the time it was structured around a discussion topic initiated by the leader and part of the time was a time for participants to share how they were doing. The second group was the Anxiety and Depressive Disorders support group, which consisted entirely of persons diagnosed with a mental health problem. In both groups participants spoke freely about their problems, sought answers and support from one another, and received feedback from other participants about what had helped them. There was an acknowledgement of the difficulty of the struggle as well as a genuine caring for one another's progress. Particularly in the second group I was impressed by the resourcefulness of the participants and how actively engaged they were

in seeking solutions to their own mental health problems and passing the information of “what works” on to others. They were truly enthusiastic supporters of mental health! I left the group with a list of resources to give to my clients at work.

Once I began my research and had chosen potential participants, I contacted them by telephone and gave them a verbal explanation of the research proposal. Of the participants contacted, only three refused to participate in the study. I enrolled ten participants. The interviews began in July 2002 and continued till the focus group in March 2003. After the initial phone contact, I gave each of them a letter explaining the research project: its purpose, how the research would be conducted, my role as researcher, and their role as participants and co-researchers. (See Appendix A.) An initial interview was scheduled, and prior to that interview I reviewed the Informed Consent (see Appendix B) with each of them and gave them a copy. The Informed Consent provided information about the purpose of the research, the role of the researcher, the conduct of the research, the analysis of the data, the use of the data, how the research protocol protected their confidentiality, their voluntary position as participants in the research, their right to withdraw at any time without adverse consequences, and their role as co-researchers (Kayser-Jones and Koenig, 1994).

Using the principle of triangulation (Maxwell, 1996), data collection was through a variety of methods. Once a participant was recruited, I reviewed their chart a second time for information pertaining to their relapse prevention plans, any assessment and prognosis by hospital staff, and readmissions in preparation for the interviews. I conducted open-ended interviews using a brief interview guide and potential themes to guide me (see Appendices D and E.) Of the ten participants, I met only with the client in

eight of the first interviews. When I met with Ben, I also met with his mother in the first interview. When I met with David I also met with his wife. In the first interviews, I persuaded three more participants to allow me to interview a family member in the second interview; however only two more participants had family members who agreed to be interviewed. I interviewed Karen with her husband and Meg with her husband.

I conducted two interviews for each participant and a focus group in order to provide for increased opportunity to engage in a continual process of moving between data collection and data analysis. I also wanted to see how a focus group would change the information obtained from individuals. I audiotaped all participants and gave the participants the option of being videotaped. Two participants refused to be videotaped, and the focus group was not videotaped at the request of one of the participants. All other interviews were both audiotaped and videotaped. In order to assess validity and determine if I grasped what the participants intended to convey (Maxwell, 1996), I summarized the first interview with each participant prior to the second interview, and during the focus group I summarized the results from all the interviews and asked for feedback from the participants. After the data collection and analysis were completed I also re-contacted the participants, discussed theoretical perspectives, and sent them a summary of the final results. In order to further check validity and minimize key informant bias (Maxwell), I had planned to contact the outpatient therapists of the participants for their clinical assessments of their functioning, however none of the patients were in therapy at the time of their interviews and only four continued to see a psychiatrist for medication management, so I did not contact any outpatient therapists.

CONFIDENTIALITY OF DATA

In order to maintain confidentiality of data I had every participant sign consent forms giving me permission to gather data from interviews by audiotape or audiotape and videotape and from their records. (See Appendix.) I kept the participant's personal information in a locked cabinet in a secure office. I agreed with the IRB at Carilion to destroy any identifying information that could link sensitive data to the participants after the research was completed and notify them. During the early part of data analysis, I hired a transcriptionist, who signed a confidentiality statement and took the test on the HIPAA requirements per request of the Carilion IRB. Identifying information was not used on the transcripts or dissertation, as codes were used.

DATA ANALYSIS

Data analysis was an ongoing process of my research and consisted not only of the official interviews and focus group, but also of any information participants provided. For example, on a follow-up phone call to Mitchell just two days after he had been severely depressed and had been talking about a conflict with his son, I thought it was significant that his son had called him and apologized, and Mitchell was feeling much better. Likewise, in a follow-up phone call with Charity, she asked me if I had a job available that she could do. Since she had earlier told me that work had been one of her coping mechanisms to help her deal with her depression, I was pleased to hear that she was wanting to work and interpreted that as a sign of her getting better.

It was important to me to involve the participants in the research process by giving them feedback on what I was discovering as I went along and then getting their

feedback. Most of their feedback consisted of amplification of the information rather than correcting misinformation. Meg's spouse did correct a couple of things about time frame and number of treatments, but basically agreed with the information. Feedback was also important to the participants, as they all wanted a copy of a summary of the final results. Some of the feedback the participants gave involved surprise at what was said. For example, Rachel, who was feeling much better at the time of the second interview, commented about her first interview, "Boy I was really depressed then." In response to her first interview, Charity also stated, "I was pretty depressed at that time."

Since I ended up doing almost all the transcribing myself, data analysis was truly a process of immersing myself in the data. I followed a grounded theory method of analysis advocated by Strauss and Corbin (1990). I listened, transcribed, read the transcripts several times, and began coding the data using open, axial, and selective coding methods. I developed a list of thirty-six concepts from the transcripts and reorganized the data according to these concepts. I then re-read the data and developed categories from these concepts. These categories became the major themes of the data, and I was fascinated to see how these themes were present throughout all of the research questions. Throughout the analysis as I tried to understand the categories and build theory I went not only to the reorganized collections of data, but also back to the original transcripts to double check and make sure that I was faithful to the voices of the participants. As I again re-analyzed the data according to themes, I became aware of the subcategories that specified the categories and the intervening conditions that facilitated or inhibited the categories. I began to link categories together in relationship to one another to form theories. I went back to the published research literature to determine if

there was any justification for my theories. There was evidence supporting my thinking and I continued to build upon my thinking.

Because I wanted an opportunity to give to and receive feedback from my colleagues at Carilion about my research, I presented an in-service at Carilion on my initial results. The in-service was held prior to my finishing all the data analysis due to my relocation to another community. My colleagues generated some discussion as a result of the presentation on the concepts of relapse prevention, for which I am grateful.

RESEARCHER ROLE

In my proposal I had emphasized the importance of being very clear about my role as researcher in this study versus my role as a therapist at the Rehabilitation Center. I was concerned that participants, some of whom had known me in my role as therapist, would most likely expect me to continue to relate to them as therapist, and I felt a need to be explicit about what my role as researcher entailed. My concerns involved ethical issues of not intervening in the therapeutic work of other therapists and also how the research itself would be impacted if participants viewed the researcher as a therapist, because I questioned whether the information that participants shared with a therapist would be different than what they shared with a researcher.

Although I was aware of the issue of whether or not a participant would see me as a therapist, I was less aware of the difficulty I as a therapist would have being a researcher. Most of the time both participant and researcher were able to treat the process of research as research and not as therapy, however one of the issues that is raised in doing multiple interviews is how much the first interview impacts and creates change in the participant's life that in turn impacts the second interview. For example, in my

second interview with Ben and his Mother, she stated, “Ben is doing good now. I can’t complain, and I don’t mean just here this last day or so, but since when you talked to him it’s still been a good thing.” Unfortunately, I did not clarify whether she meant “because” I talked with him, or simply “since that time”.

The following is an excerpt from a memo I wrote to myself after an interview with Charity, that expresses my process of wrestling with these issues:

I had one patient, Charity, suggest seeing me outpatient, and I had to refuse. This indicates to me the difficulty of differentiating between therapy and research. The two are really interconnected. To relate to another person is to have an influence on that person’s life. No matter what our role, we must always be aware of our ability to influence. This also raises interesting issues for the research, in that how will I ever figure out how my role influenced the outcome of the research itself...Ethically, should I not say encouraging words when the opportunity arises...have I crossed the boundaries of research? No, rather to not do so would be to cross the boundaries of humanity. Simply, the dilemma points out an inherent difficulty of research...Actually, underlying all this is the basic question of what is research and what is its purpose? Is research only valid if it has no human influence? That question comes from a flawed way of viewing the world.

Not only did my role as researcher/therapist raise issues about my influence on the outcome of the research, it also raised ethical issues. Mitchell was a highly depressed participant and needed to get help. I ended up assessing him for suicidality. The need to do an assessment certainly influenced the direction of my research questions, however I

was also able to ask significant questions about relapse prevention, and I believe the information he gave me was significant. The ethical issues were if and how I needed to intervene. The following is an excerpt from my memo about that interview:

I experienced my limits as a therapist and a researcher in dealing with the unpleasant emotions within me. I was glad to leave, yet worried about him. I called and checked on him several times and re-determined that he was not going to hurt himself...when is admission absolutely necessary and when does one wait? Issues of freedom and coercion arise. Client's are often in positions of needing help, not seeking help, and yet not quite meeting the criteria to be forced to have help. This is difficult enough as a therapist, but facing this issue as a researcher/therapist created inner conflicts within me. I didn't want to sabotage the relationship and "risk" alienating a participant, yet clearly safety issues always take precedent. Yet I confess part of the relief I experienced when I assessed that my client was not overtly suicidal and not in immediate need of hospitalization was not just for the client, but also for me. How willing am I to live with my discomfort and to do what is best for the client? These are character-building questions, and every therapist has to answer them when making a commitment to enter this field. Every researcher must also deal with them.

LIMITATIONS

Every research project has limitations. Some of the practical limitations that I experienced were my time, the IRB renewal deadlines, tuition, and the need to finish and graduate. I also ended up having to encourage my transcriptionist to quit, because she was not able to do the work. Because of the IRB guidelines and my own financial

limitations, it was easier to do the transcriptions myself, which significantly lengthened the time of the research.

There were other limitations of research, however, that to me were more important. As a qualitative researcher, I was aware that my perceptions would be affected by my experiences and beliefs (Kiser and Piercy, 2001); however, I was startled to realize that I discovered that the theoretical underpinnings of my “newfound” theories blended with and, I suspect, were influenced by my belief systems. The following is an excerpt from my journal about theory development:

The importance of collegiality in research cannot be overemphasized. As I began to process my thinking about analysis, I realized that I had come up with a theory that I firmly believe in, but which comes right out of my experience. I cannot seem to separate myself from the lens with which I normally see things, try as I might to lay aside all prejudices. I am bound to and am the product of myself, and that which I produce is also a product of who I am as well as of that which I have interacted with. One way to broaden and test my lens is through the lenses of others. The collegiality of ideas expressed in conversation is one of the most precious aspects of a university, and I regret that I have failed to take advantage of it after leaving. Fortunately, the collegiality of ideas also exists in the writings of researchers and theorists and clinicians. For that, I have been truly grateful, and it was with immense relief and excitement that I discovered that my thinking was along the same lines as some of the experts in the field. S. M. Johnson has managed to combine a love for therapy with a dedication to research which sets a powerful example for those of us in the academic community who

believe that it is in the interaction of the two that we are all bettered and our work is bettered. Although writings are a form of conversation, I do not see them as a substitute for voice communication... The highest form of intimacy is presence, and the opportunity to express a collegiality of ideas is a form of intimacy.

In addition to the limitation of perception, I discovered the limitation of motivation. Some participants verbalized wanting to help others as their reason to participate in the research. One participant wanted to help the researcher, because she had a neighbor doing research and understood the difficulty of recruitment. Another participant never gave a reason for coming, however, in the interview she asked me to put in a good word with her doctor so that she could get a certain type of medication. A few participants simply appeared lonely and wanting someone to listen to them tell their story. Whatever the reason, it raised the issue for me of how did peoples' motivation for participating in the research affect the results? What information did they share based on what their needs were at the present time, rather than on the research questions?

Systemically, I could also ask how does the researcher's motivation affect the results?

For example, I intentionally interviewed Ben four days prior to his impending court date and incarceration because I wanted to get the interview done prior to his incarceration,

but also because I was curious about how that would impact the interview itself. If

research occurs over time, which mine did, how is the motivation itself influenced by the interaction with the researcher in the various interviews and how does that then affect the results? I do not have answers for all of these questions, but I am aware of the issues and find them interesting.

CHAPTER IV

A DISCOURSE ON DEPRESSION

INTRODUCTION OF THE PARTICIPANTS:

History, Treatment, and Current Circumstances

Cathy

As the Psychiatric Lead for Clinical Services at Carilion Roanoke Memorial Hospital Rehabilitation Center, I have been engaged in seeking to help many patients who often enter the hospital in crisis decrease their depressive symptoms and increase their confidence in their ability to manage their depression and the various problems that feed into it through developing a plan of relapse prevention. As a researcher and candidate for the PhD in Marriage and Family Therapy, I have been privileged for the past several months to be in conversation with the following participants in a research project designed to understand what participants in our relapse prevention program experienced post-discharge and what they have to teach us about depression. In order to honor their voice and to give readers the opportunity to hear for themselves what has been shared, whenever possible I will use quotes from the participants to illustrate findings. As a participant in the conversations, when appropriate I will also share my questions and comments so that readers may determine for themselves how the nature of the discourse was influenced by the interaction of the participants.

Julie

Julie is a thirty-two year old separated mother of four children who first developed depression symptoms at age twelve, but did not experience treatment until she was an adult. She is the oldest of three children and her parents divorced when she was

older. Her father was abusive. Julie's first son, age 12, was the product of her first marriage and has ADHD. She remarried and had three children within a span of four years. She is separated from her second husband, and is not able to afford the cost of a divorce. She had two psychiatric hospitalizations within a year of each other.

The first time I came in, two years ago, I came in the day, that afternoon that I left court, because I dropped the emergency protective on all of us, kept it on me, but dropped it on the kids. He had hit me a couple of times. That's why it was in effect. I was afraid of him taking off with the kids, and I was overwhelmed by the three weeks of having to rely on Momma. I was afraid to stay at the house by myself. I worked midnights and the kids had to stay with someone, and then the things, the sexual assault, all that stuff with him.

Her dysthymia developed into major depression and with both hospitalizations she experienced suicidal ideation, but denied intent because of her children. She was treated with medication for the depression and for her inability to sleep. She was given a follow-up appointment with a psychiatrist and therapist. Unable to see a doctor at the local Community Service Board (CSB), she went to a private psychiatrist and subsequently could not afford to see a therapist.

Researcher: The systems in your life, how have they helped or hindered your depression?

Julie: I think it was when I got out of here last year, and I was trying to get back into (CSB) because of the financial issues, and she said 'it's a two, three, four month waiting list', I'm like, excuse my colorful language, 'in the fucking

meantime someone can kill themselves and not receive any help because you have that big of a' ...I was like, forget it.

At the time of the first interview with Julie in the summer, she was unemployed and was going full time to a community college with plans to finish within a year and transfer to a local four-year college where she intended to get her degree. She was living in a house with her children, and she and her husband took turns staying there with them. She broke up with her boyfriend, her depression increased, and she was on medication to manage it. At the time of her second interview in the fall she continued in school, was working at a part-time job, had a new boyfriend whom she felt was very supportive, was eligible for Section 8 housing and moved into her own home with her children. She was looking forward to finishing her community college that year. She was no longer on medication. At the time of her participation in the focus group in the spring, she was accepted to the local college on a full scholarship and was given a scholarship to travel with a class overseas for two weeks in the summer. She no longer had a boyfriend and remained off medication. She was not in treatment.

Gloria

Gloria is a sixty-three year old widowed mother of one adult daughter who was the daughter of a depressed, emotionally distant father and a mother whom she described as codependent. She has a sister whom she has not seen in twenty-two years. Gloria was high functioning much of her life, working as a psychiatric nurse with a Masters in Rehabilitation Counseling. She married three times. The first marriage lasted briefly and ended in divorce after her spouse was abusive and unfaithful. The second marriage lasted several years and resulted in the birth of her daughter. That marriage also ended in

divorce after an affair by her spouse, who was emotionally abusive. Her third marriage was to a man who had alcoholism and who died two years prior to her hospitalization. In the latter part of their marriage she functioned as a nurse for her husband, who needed total care.

After her divorce from her second husband, Gloria had primary custody of her daughter and worked to support her. She denied herself several opportunities to socialize in order to be with her daughter. She considered herself to be close to her daughter at one time, but as her daughter grew up they had problems, and she was not invited to attend her daughter's wedding and had not seen her in over 9 years. Her daughter did send a picture of her only granddaughter when she was born.

As she grew older Gloria developed several major health care problems including osteoarthritis and spinal fusion surgery. Eventually she became disabled and unable to work. She received outpatient treatment for depression by both a private psychiatrist and a therapist. She was hospitalized the week before Christmas with suicidal thoughts.

First it was situational depression, but then last Christmas it developed into clinical depression and that's when I ended up in the Rehab, right over Christmas; because I couldn't stop crying, because here I am sitting all alone in an apartment, and where's my family, and they're all dead and they're gone, and both my parents suicided in their own way.

Gloria participated in two interviews as part of the research. The first occurred in the summer eight months after her hospitalization. On a limited income and needing mechanical assistance in walking, she had recently moved to an apartment complex for people with disabilities and lower incomes. She remained on medication and regularly

saw her psychiatrist, however, she had stopped seeing her outpatient therapist. The second interview occurred in the fall shortly after she was in an automobile accident that resulted in an injury to her arm. At that point she was not really able to get out of her apartment much to do things. She contacted several supportive resources, which were helping her. She remained on antidepressant medication. Gloria was not able to come to the focus group because she was recovering from minor surgery.

Karen and Adam

Karen is a forty–five year old married mother of five children with one teenage daughter and one teenage son still living at home. Her first marriage lasted sixteen years. They separated and she met and lived with her current husband as a partner for eight years. Karen’s extended family has many members who have alcoholism. After her separation from her first husband, she drank daily for two years, but then sought outpatient treatment and was put on an antidepressant, which she subsequently stopped due to side effects. She did not pursue further treatment, however she severely limited her drinking.

Karen was very close to her parents. In 1998 her mother died. Two and a half years later her father died, seven months before her psychiatric admission. She had experienced some symptoms of depression since the death of her mother, and after her father’s death the symptoms began to increase. During that time she also had increased conflict with her boyfriend, and he finally told her he was leaving.

My father passed away in February of that year and then I went through a time where I couldn’t sleep...for about three months and I wasn’t happy with the way things were in my life and with my relationship. I felt like he hadn’t been

there for me when I lost my dad... And then when he told me he was leaving, it was like another death to me because I had been with him for over eight years. So, I just, I felt like I couldn't take anymore and needed a break from life... I just felt like everything was out of control.

After her hospitalization, Karen and her boyfriend Adam separated. She stayed on the medication she had been given approximately one or two months until the prescription ran out. Due to transportation problems, she did not keep her follow-up appointments and did not try to refill her prescription. She and her boyfriend continued to communicate during the time that he stayed with his new girlfriend. They reconciled, he left again, and then they reconciled after a longer period of separation while still seeing each other. At the time of the first interview they had worked hard on communicating about their differences, including working through feelings about the girlfriend's pregnancy by him. They were planning to be married in the later fall. Karen remained off medication and did not seek any form of mental health services. At the time of the second interview she had married and her husband agreed to participate in the interview. She had occasional mild episodes of depression but was not on medication and did not feel she needed help. Karen was unable to come to the focus group due to surgery three days before the meeting. She remained off medication and without the need for therapy.

Rachel

Rachel is a forty-six year old married mother of two children whose father died when she was eighteen, and she has had depression since that time. She married and was

physically abused by her first husband, who is the father of her twenty-year-old son. She remarried and describes herself as in love with her husband of twenty-four years.

Rachel had problems with alcohol earlier in her life and was an active member of AA. for ten years. She works full-time. She has had two back surgeries for a ruptured disc, arthritis in her back and has Fibromyalgia. Her husband is on disability for back problems and is on pain medication for his back. Rachel became addicted to pain medicine and began stealing her husband's medication.

I spent almost the entire month of April last year in the Rehab. The first time I spent like five or six days, and uh, over the years they've had me on I don't know how many antidepressants. They'd work for a while and then wouldn't work for a while. The first time I was in the hospital last year they put me on an antidepressant called Remeron, and uh, I had a really violent reaction on that medication. It got to the point I took an overdose one night and ended up back in the Rehab.

After Rachel's first hospitalization, she was scheduled for outpatient therapy at the local community service board, however she was not able to get an appointment for a month. By then she had overdosed and reentered the hospital: "I was released from the hospital the second time, and things were okay except that I still didn't feel like a whole person."

After her second discharge Rachel did see someone at the Community Service Board, however she did not continue there, because she felt labeled as a drug addict and did not feel her depression was being treated properly. At the time of our first interview in the fall of 2002 she was not on any medication and remained very depressed,

expressing continued negativity towards her spouse, whom she felt did not understand depression. She was trying to seek treatment through her family doctor. Because she had lost her job and had not worked continually, she did not have insurance coverage for preexisting conditions and could not afford to see a private psychiatrist.

And, um, so I started doing some research myself on the internet, and my family doctor agreed to try me on an ADHD medicine, and since then I feel like a real person. I think that I was misdiagnosed for years and years.

At the time of our second interview in January 2003, Rachel was on medication for ADHD but not on an antidepressant. She was less depressed, felt her husband, who was facing surgery and was now also dealing with depression, was understanding; and she was trying to schedule an appointment with the psychiatrist. She attended the focus group in March 2003 and by that time saw a psychiatrist and started on Wellbutrin. She indicated she was “feeling good.”

Ben and Betty (Mother)

Ben is a twenty-year-old single male who has one older sister and lives with his mother Betty in a small rural community. His father, who had alcoholism, committed suicide in front of him when he was six with a shotgun. Other members of Ben’s extended family had problems with alcoholism and drugs and either attempted or completed suicide. In addition, Ben watched his grandfather die of a heart attack with paramedics being unable to revive him. In recent months prior to his admission Ben’s uncle had died, and his girlfriend, who was living with him, broke up with him. Ben got drunk and got into legal trouble and was facing a court date in two weeks with potential

jail time. Ben came to the hospital under a temporary detention order after becoming quite drunk, making suicidal statements, and putting a loaded gun in his mouth.

The reason I've always been suicidal is because I felt like I was so alone there was nothing else I could do, you know, and there's no hope for me because I'm so alone, and I don't have nobody that I feel like could truly love me and all this, and I don't have nobody to sit down, no friends or nothing to talk to and stuff. That's what I felt like...I didn't want to be there so alone.

He did well in the hospital, had a family meeting with his mother, who is very supportive of him, and was discharged to outpatient therapy with the local community service board.

I went up there and sat down and had a one-on-one with the woman. I sat down and you know she was like "Well, tell me your story," just like I'm telling you now...so we could figure out what we needed to do. I sat down and told her about my father and the life that I've lived and the drugs that I've done, you know, how I felt. She looked at me and I remember her exact words. She said, "You're too messed up for us to deal with." She said, "You're gonna have to find professional help, somebody that you are going to have to pay to find their help." And when she said that I got up, I just got up, turned around, didn't say another word...walked out the door and got into the car with a buddy who had come to pick me up. I called him. I got in the car and we went to Lou's Store and got a fifth of liquor.... I had so much hope and so much faith in going to that place and she looked at me and said, "You're too messed up for us to deal with" and it just broke my heart. I was like, "Well, what's the use." I was going back to my old

ways because I was happier. I didn't have to hear people tell me how screwed up I was.

Ben's Mother: He called me and he was sobbing crying. He said, "Momma, I'm worthless. There's no point in me even trying." He said, "I'm not worth nothing."

After getting drunk that day, Ben again got into trouble with the law and at the time of the interview was facing going back to court with jail time. I interviewed him in the fall seven months after his admission and in the meantime he went to court for the charges he had been facing upon admission and served jail time for that. In the jail he was not able to get the antidepressant medication he had been prescribed at the hospital, and he became hooked on drugs, shooting the drugs into his veins. He started detoxing at home after he was released. When his mother took him into the emergency room seeking admission for the detoxification, his insurance refused to pay, because he was already partially detoxed. He finished detoxing at home, and remained off drugs and off medication. He had several symptoms of depression, but was very proud of himself for remaining off drugs. He admitted to occasional drinking.

I interviewed Ben again just four days prior to his court date. Ben had made a plea-bargain and knew he would leave from court for jail. He remained depressed, off medication, proud of his non-drug use, and trying to think positively about his future. He was relieved that he would serve a relatively short sentence. When I re-contacted Ben three and a half months later to invite him to the focus group, he had just gotten out of jail two days earlier. He stated that he did well in jail and was on a work crew with privileges to leave the jail. He did not relapse on drugs. He was not on medication and

knew that he needed help because he was having frequent panic attacks. He planned to come to the focus group, but did not show up. I called to check on him and his girlfriend informed me that he had been working.

Charity

Charity is a seventy-seven year old married mother of three adult children and two grandchildren. She was raised in a small rural area and was very close to her parents growing up. She first experienced symptoms of depression and anxiety when she attended college. She would stay up late every night studying and eventually became fearful that people were always watching her. She dropped out of college and her mother took her to a doctor for treatment.

We had a time with me for a while, for we didn't know what to do with me, and then finally we ran into...this Christian doctor...and we went to him, and the man sat me free. I didn't take a bit of medicine, I was just in counseling with him. Talking about the God, about all the things that you go through in life just helped me come to a reality of life, and I got better. The only thing he told me was, he said, 'Now, when you go back to school, don't try to make no A's. Don't do that, cause you're putting too much pressure on your mind.'

Charity graduated from college and moved to a larger city, where she worked, married and began to experience depressive symptoms again.

It was just after I married, the man that I married, that it came back again, cause I was scared of him. I didn't know he drank and raged and stuff. And I didn't weigh but, I guess I weighed about 98 pounds; and he's a great big man. And then I had my oldest son. It was a traumatic situation. That's when I started

getting sick again; because I was afraid of my husband, I was expecting a baby, and not really knowing what to expect.

Charity sought treatment, was put on medication and has remained on medication for depression all her life. She has seen psychiatrists regularly, but in the last several years has been treated by one particular psychiatrist whom she feels close to. She does not see a therapist. She has functioned well all her life, working full time as a teacher, raising three children, and being very active in her church. She credits the medication with enabling her to function.

You know how you just try to think about what is going on with you that you can't get better. I been sick every since I still think it's when, that's how it all began. I mean, I guess it's emotional. I don't know what it is. I know that I cry a lot, and going to see him like he is now. He's lying there attached to a feeding tube. They had us sign some papers that if something went wrong, what did we want them to do. And we just said, don't keep him hooked up like that, cause he's been through so much. Let him just be normal, and if he goes, he goes. But then they still give him the feeding tube.

In addition to the problems with her spouse, Charity became overwhelmed and sought hospital admission when her son relapsed on drugs. While in the hospital, her medications were changed and she was given an appointment with a psychiatrist associated with the hospital upon discharge. She went but was having trouble with the medication and did not like the psychiatrist, so she returned to her old psychiatrist and he put her back on her old medications.

At the time of our first interview she remained depressed and had physical health problems for which she was anticipating rotocuff surgery. At the time of our second interview she had opened her home to a homeless family and was babysitting for the children. Her depression lessened, and she was still anticipating surgery.

And right now I'm doing pretty good. And really these kids have made me feel better. Really it's been a joy to me cause I hate being here by myself. Well, actually I'm doing better because I have people around.

Charity planned to attend the focus group, but she did not show and when called explained that her church meeting ran over and she was unable to get out in time to come. She continued to do well.

David and June

David is a fifty-nine year old married father of three sons with a maternal history of depression. He denies experiencing any abuse as a child. He worked as a carpenter most of his life, but has been on disability for the past thirteen years for angina and diabetes. He has a history of alcohol problems but stopped drinking twenty years ago. He has been married thirty-nine years. His three sons live locally, he sees his family frequently, and he and his wife June often baby-sit for their grandchildren and great grandchildren, to whom they are very attached.

David has experienced two psychiatric hospitalizations. He was first admitted in 2001 and was treated for depression and possible early dementia. He did very well, but developed physical problems and became unable to sleep. He tried to get help for his abdominal pain, but the doctors were unable to diagnose and treat the problem quickly, and he was told when he went into the doctor that he was developing congestive heart

failure. He became upset and went home, found his rifle, which he thought was loaded, and pointed it at his head and pulled the trigger. He then was brought to the hospital for his second admission on a temporary detention order.

Wife: Ah, I think he'd been, probably it was several weeks he'd been depressed. He wasn't sleeping, and his appetite, he wasn't eating as well as he had been. And he didn't have no interest in anything, and he didn't want to keep his body clean like he used to ... Well, he sat there...in front of the TV, but whether he was watching it, I don't know. Looked like everything was just overwhelming to him.

After his second admission David continued with his outpatient visits with the psychiatrist, and he responded well to medication management. At the time of our first interview he was doing well. I came back for a second interview and he and his wife were quite excited because they had begun to socialize and play cards with a large group of friends and family, and they were now anticipating their first vacation getaway in quite a while with some of these people. They planned to come to the focus group, but were unable to actually attend at the last minute due to company dropping in on them. He continued to do well.

Mitchell

Mitchell is a fifty-one year old divorced father of four children who lives with his eighty-seven year old mother, has diabetes, and was born diagnosed with Hirshsprung's Disease. He had surgery for a colostomy when he was three days old. He has had over a hundred operations since then. He was close to his parents, but his sister physically and sexually abused him, and he is not close to his sister. When his father died, he and his

wife moved in with his mother. He developed diabetes and has had an amputation of the right leg below the knee. He has also had a cerebral vascular accident with left sided weakness. He navigates with a four- prong cane or a walker and for long distances uses an electric wheelchair.

Mitchell graduated from high school and went to two years of college. He worked as a correctional officer in the prison system for five and a half years. He also did duct work for a contractor for several years. He has worked most of his life, but stopped working and began receiving disability because of his medical problems three years ago. He has financial and relational stressors.

Mitchell has had depression for several years. He had his first psychiatric hospitalization eight years ago when he was dealing with his divorce and when he lost his leg. He tried to kill himself with a gun, which his oldest son prevented. He was not on any medication for depression when he was admitted to the Rehab, nor had he had regular mental health follow-up in recent years. Prior to his admission to the Rehab, his sister wanted to admit his mother to a nursing home, which would result in Mitchell being unable to continue to live in her home. Mitchell also had his driver's license temporarily suspended at the request of his endocrinologist because he went into diabetic shock and lost consciousness while driving, wrecking his car and damaging a house. He was now afraid to drive but also hated to be dependent on his family for help.

I lost my license and that was pretty bad. The doctor wouldn't let me drive a car...Back when my leg was gone, it's not like I just held it up and said phooey. I was still moving. As long as I was still moving I was trying to do

something... I just felt helpless... I got tired of living the way I was living and said "the hell with it."

He stayed eight days and was discharged on antidepressant medication and with psychiatric follow-up.

At the time of the first interview, Mitchell was no longer on antidepressants, nor was he under the care of a psychiatrist or in therapy.

There are times when I do need medication. There are times when my get up and go down and about took me with it. That's the way I feel... as long as it don't cost me \$17 a pill. I ain't got the money.

His diabetes was under better control and his doctor gave him permission to reapply for his driver's license. He was unable to find someone who would take him to the Department of Motor Vehicles to take the test. Because of transportation issues he also had a difficult time getting his medications, however he did do so. Mitchell remained quite depressed, however he denied suicidality.

At the time of the second interview, Mitchell had developed gangrene in one of his fingers and was in a lot of pain and realized that he would most likely need an amputation. He had argued with one of his sons and felt isolated and alone. His mother was undergoing tests for heart problems. His depression increased, and he was verbalizing suicidal thoughts but denying intent or specific plan and was able to guarantee safety. He was willing to call for help. I gave him the information to call a psychiatrist for an evaluation for medication; however, his immediate and primary concern was his gangrenous finger, and he first called for help for that. After the interview I called and checked on him several times. He was doing better emotionally

because his son called and apologized and he felt things were better between them. I called to invite him to the focus group, and he was unable to come. He was on his way to the hospital to have his finger taken care of.

Gwen

Gwen is a forty-eight year old single woman who has seven brothers and sisters and lives by herself in a home she is buying. She has always been an independent, adventuresome person and has been very close to her parents, who are divorced. She has worked for several years as a supervisor of a production line in a factory. Gwen has a history of alcoholism and depression. She was treated once before at a local hospital for her alcoholism and depression, and remained on medication for depression and at the time of her admission to the Rehab had been sober for five years. Gwen has diabetes.

Gwen has been in a relationship with a partner for twenty-eight years. He is an alcoholic and was living with her until two weeks before the focus group. Their relationship became increasingly strained due to his current and frequent history of job loss because of his alcoholism.

Gwen's father remarried two years ago and since that time has gradually been separating himself from his children, which put a strain on her relationship with him. Her mother is a diabetic with serious health complications. She lived with Gwen for two years after she began having strokes; however, she started having circulation problems in her legs and after the first year had to have an amputation on one of her legs. Gwen continued to care for her mother at home; however, she was unable to find help from her siblings or others to care for her mother during the hours she was working, and eventually she had to go on family leave from work to care for her.

And I called and said “Hey I need help” and “D. why didn’t you give this some thought. You should have knew what you was taking on before you took it on. Well what are we supposed to do?” I said, “You’re supposed to help me.” “Well, I don’t have time. I have a family.” I said, “But you also have a mother.” “Well, I just don’t have time.” And to keep from arguing with them I just hung up the phone and never asked for help again. And, with, you know, trying to take care of her and trying to take care of her bills, her finances, and my bills, my finances everything just went out of proportion. I did what alcoholics do. I picked up a drink I would go off to myself out back and cry. Doctors even said, “The inevitable is going to happen,” and when it just started happening it was just too much.

Eventually Gwen’s mother had to have her other leg amputated, and at that point she went into a local nursing home. Two months later Gwen came to the Rehab for treatment of her depression and for detox. She had suicidal ideation without intent or plan. She was treated and discharged on antidepressant medication and given a follow-up appointment with a psychiatrist.

Gwen kept her initial outpatient appointment, but did not continue to see the psychiatrist. She did remain on medication. At the time of the first interview, she was doing well, was depressed at times, and was managing it. This remained true during her second interview; however, her stress had increased because of the length of time her boyfriend had been unemployed. Gwen came to the focus group, remained on medication, and was not seeing a psychiatrist or counselor. She had recently asked her boyfriend to leave her home, however she did not indicate increased depression.

Meg and George

Meg is a middle-aged mother of one daughter who has a close relationship with her spouse and has functioned well in her family and professional roles. She has an RN and in the past has worked in a variety of nursing jobs, including a highly stressful job in Cardiac Surgery ICU. An only child, she was very close to both of her parents.

The first time I recall being depressed was shortly after my mother died, eleven years ago. I wasn't really treated, I don't think, for any depression until about 8 years ago. I'm an only child and uh, anyway I just was very close to both parents. My mother had breast cancer, and uh, I guess I tried to be the daughter and the nurse to them both, and it was very difficult. They were three and a half hours away, and I just made numerous trips back and forth. When my Dad became ill I would try to be a mother to my daughter and a daughter to my father, and I just was having a very hard time.... He passed away 8 ½ years after my mother did... We're not very close to my husband's family, and I just didn't really have much support from them, and, um, fortunately my husband's been very supportive.

Meg has been in treatment for her depression since she became depressed. She has been on numerous antidepressants, has had ECT, has changed psychiatrists several times and has had multiple hospital admissions. She has not worked since 1996. She entered the Rehab for a course of ECT to help her manage her depression when the current antidepressants were not sufficient and her depression was increasing.

But this past time it seems like I got very paranoid about things; um, at least prior to the admission I was experiencing a lot of paranoia. I felt like people were turning against me...when they really weren't.

After discharge, Meg resumed her routine follow-up with her psychiatrist. She remained on antidepressants. She did not see an outpatient therapist, as she felt that had not been helpful in the past. By the time of the first interview she resumed her normal functioning and her depression decreased significantly. She continued with her normal methods of treatment. Her spouse George came to the second interview. He also felt she was doing better and remained very supportive of her struggle to manage her illness and of her progress. Meg and her husband stated they would try to come to the focus group, but were uncertain whether they could come because they had already made plans to be out of town. They did not come.

VIEWS OF DEPRESSION AND CONFIDENCE IN MANAGING IT

Defining Depression

Many of the participants knew that they had been depressed for years. They were familiar with the symptoms and could tell when their depression was growing worse. Julie saw her depression as chronic, accepted that she had it, and described it by saying: "It's been here forever, I mean, let's find a way to cope with it. So that's what I'm doing." She saw herself as responsible for her own healing process:

The doctor tried to help me with everything he could think of, and I just finally said, "I have to stop taking all this medicine and do it on my own."

In describing the comments her son's doctor made about his medication, she revealed her own thoughts about taking medication to treat depression:

The doctor says, 'The medicine is your helper, it's not your fixer. You've got to learn to fix it. The medicine helps you fix it.'

She sees her depressive feelings as temporary and therefore manageable:

It's just knowing the clues and knowing how to interpret them...you know, you used to think, you'd wake and you'd feel bad today, well the rest of your day is screwed. Get up and move on. So that's what I'm trying to do.

In describing her efforts to get up and move on she expressed her guilt at how her efforts to heal herself have impacted her relationships, but she also described a loss of self that happens with depression:

Some people may not like the things I say and do or how I act... I can't please everybody. Some days I feel guilty because I'm not with the kids all the time, but if I'm with the kids all the time, I'm going to be right back where I was two years ago, with no identity, no wants or anything.

Gloria also saw her depression as chronic, although she defined different types of depression: "situational" versus "clinical". She related the development of her depression to "chronic stressors", particularly in relationships: "I've had so many stressors in my life and it's mostly related to my family and to the men I've chosen to be with in my life." Although she was aware of and used many different coping skills to manage her depression, she also described depression as something that comes upon her unwanted and without her control, such as in this description of a recurrent dream about depression:

I'm riding along a narrow little road in a Volkswagen, or a little car that you just barely fit into, and I flip off the road into this wet field, and I keep going

a little further, and there's a big sinkhole, and I say 'No, I don't want to go in that again. I don't want to go in there.' And then I start going toward the sinkhole, and I start sinking into that big sinkhole, and it just sucks me up, and sucks up the car and the whole thing, and I am gone, and that's a scary dream.

What is most striking about this description is her loss of self. When depression takes over, she is "gone". She also described depression in terms that indicate she could not see her way out of it: "I think it's like going way down the bottom of the well." Her thoughts indicate a lack of ability to heal herself and a dependency on God for healing: "You know I keep thinking, 'Please Lord when is it ever going to get happier? When are we going to have some happiness?'"

Karen had never been diagnosed with depression before her hospitalization, so she did not really understand what it was. She perceived depression mostly in terms of her feelings.

I was going through depression. I didn't really nail it, you know, I didn't really say, 'Okay, the reason why I haven't slept for three months is because I'm depressed.' I just knew that I was not happy.

Karen also perceived depression relationally: "I think if one person is depressed and the other person is not, sooner or later that other person will be affected by it and the relationship will be affected by it."

She believed that her own sense of self was affected by the relationship and her depression. She also described herself as gone:

When I got out of the Rehab I felt a lot stronger. I learned to laugh all over again and enjoy myself and I felt like I was somebody and I realized that I

might have lost myself a little bit because of the relationship... I knew there was something there that I didn't realize was there for so long because of the depression and him distancing himself from me and I think he felt the same way because it was like 'Oh boy there you are, I haven't seen you for a while.'

Rachel believed her depression fluctuated with medication working only temporarily:

That's what it's been like the first 20 years. They'd put me on, like an antidepressant, and it would be okay for the first few months, and then I'd start feeling all down and yucky stuff again.

She saw multiples factors contributing to her depression: cost of medicine, medical bills, change in weather, but ultimately she recognized everything could increase it and questioned the meaning of life:

I think that life in general is depressing, when things are just so routine; like get up do this, do that, go to work, go home, go to bed: boring and dull. I mean why are any of us even here? It's just work...I'm starting to think that it's (life's) only good in my imagination, what I want it to be like...that there's not any real happiness in life; it's only in the life that you can imagine, how you wish things were.

Rachel described her depression as a "black hole inside" and used language indicative of her sense of powerlessness to change it: "I just wish that it would go away." She too connects her depression with the way she feels and describes a lack of motivation:

Don't even have motivation to get ready to go do anything really. Like on my days off I just don't feel like doing anything, and then I'm not doing anything and sitting around being depressed because I'm not doing anything, but I DON'T FEEL LIKE DOING ANYTHING!

Ben described his depression as something that came and went and in terms of lack of motivation and feelings.

I still have mental problems. I still have the depression. I don't feel like I have the depression for a day or two and be fine for a week. I feel like I go into depression for a couple of months at a time and then be fine for a couple of months at a time. That's the way I feel like I do because for a couple of months at a time I don't have the heart to go take a shower...I still wake up miserable...

Although Ben saw his depression as cyclical, he also recognized that it was influenced by his circumstances:

I just, I ain't been working for one thing, I ain't had no job and when I don't work, I get real depressed when I don't work. Not having a driver's license has hurt me a lot too.

Ben tried to hide his depression from others because he believed he would make others depressed:

I mean, everybody, doctors, people I've known a while, family doctors and stuff tell me I'm not depressed, 'You're smiling and happy all the time and cutting up.' Well, you all aren't much of a doctor because that's just a big front. I just don't show it and I try not to let other people know I'm down because I don't want to drag nobody else down with me.

Although Charity has been treated for depression much of her life and recognized her depression as chronic, prior to her hospital admission she did not recognize her symptoms as depression. She thought that multiple stressors influenced the severity of her depression: “just looked like it was a multiplicity of things going on”.

David also did not understand his current depression. He had not experienced a lifetime of depression, and he described himself as being depressed only for a few weeks before his hospital admission; however his wife described him as being depressed for much longer than that with a gradual worsening of symptoms.

Well, he, yeah he's been, the last few months or close to maybe a year now, yeah he's been really depressed. He wasn't that way, till, well I'd say maybe about a year ago, a year and a half. It was kind of an on and off thing, but then, then he got really depressed, and it seemed like it was something that just hung with him.

Neither she nor her husband had any explanation for why depression came, however, she recognized that they had financial stressors that might have affected him.

Mitchell also saw his depression as chronic and as something that came and went. “Some days it doesn't bother me, some days it does.” He associated depression with a lack of motivation: “It's like I don't have any reason to go on.” He knew that his health problems influenced his depression and an inability to change things.

Although Gwen tended to focus on her mother's present circumstances as being a primary contributor to her current depressive episode, she understood the power of relationships in influencing her depression throughout her life:

I've never had the relationships I deserve, as far as boyfriend/girlfriend from day one. From the time I was 18, which was when I first found out what man was like until now, I've never found a man who treated me like I was supposed to be treated. In the beginning with my first boyfriend I got beat, had my baby beat out of me, and every man after that just was beneath me. And so as far as your depression, mine started from a long time ago.

Gwen viewed her depression in relationship to her behaviors. She recognized her symptoms of depression, but did not know what to do about them:

I get depressed sometimes and that's when I eat and that's when my diabetes gets out of control. I eat as long as I'm awake, so I have to make myself go to sleep so I won't eat. And I know I can't keep doing that, because when I take that sugar and that meter say 500 I know I can't keep doing that. I'll be in the same situation as Momma is. I know what I need to do, doing it is the thing.

Meg dealt with chronic depression for years and no longer believed that it would completely go away. When the depression started she described a sense of isolation because she knew that others were not depressed and she did not understand why she was depressed. In searching for reasons she ended up blaming herself. She also described the depression in terms of feelings and saw herself as powerlessness to control it once the cycle started. She feared not getting better, however, she was aware of her cycles including the process of recovery and vividly described them:

It's very frustrating to feel like everything is closing in, but yet you know you're the only one that is feeling that way... You just wonder why am I feeling this way if the other person around me is not feeling that way. I always question

is it something I did or said. What did I do or say that was wrong? It seems like it's nothing that I'm able to do at the time to change the way I feel, unfortunately...sometimes you just feel doomed... I usually feel overwhelmed at the time that I'm experiencing those feelings. I guess initially when I'm first getting, when I'm more depressed than not, I'm thinking 'Well is this going to get worse before it gets better?' and then as the time passes I start to think more positive about things, once I start to have more therapy or whatever the treatment is at that point, then I'm starting to think, 'Well, maybe I'm going to get better. Each time, thankfully, I've gotten better and gotten through that, but not always a hundred percent...

Meg's husband was also very involved in her treatment. He tended not to dwell on cause but focused on recognizing symptoms in order to help her:

I've seen it run in cycles, and um, I think I'm closely attuned to the signals from her of when things are getting worse for her, and can pick up on those quickly and deal with it, by maybe helping her to see a doctor or to call him and freely tell him, 'This is what I'm seeing going on right now,'

Monitoring Progress

I had multiple contacts with participants over several months. Consequently I was able to understand that progress is a process that occurs over time and appears to be influenced by a variety of factors. Some participants had progressed to a fairly high level of emotional functioning when I first interviewed them and remained at that level, however other participants were still relatively depressed during the first interview and made significant progress by the time the focus group met. Unfortunately one

participant, Mitchell, whose health deteriorated, also deteriorated emotionally. Even so, he had days that were more positive than others, which he attributed to positive relationship experiences.

All of the participants had a sense of their progress or lack of progress. Some of them consciously monitored their progress on a regular basis.

Decrease in Depression

Many participants monitored their progress in terms of their symptoms and how they handled things. Julie stated:

As far as wanting to sleep all the time, it's gone. That's under control.

And I'm off the sleeping pills. I can actually lay down now and go to sleep

Not every day is perfect,. Some days I don't get a handle on it like I should, but it's getting better, you know. I know it is.

Gloria monitored her progress in terms of her vision for the future: "I'm starting to climb back out of that well and I'm starting to see possibilities for myself in the future."

Karen still acknowledged depression, and felt very comfortable with managing it: In describing why she no longer has significant depressive symptoms, she outlined what she believed helped her to get better. She knew who she was and was comfortable with her identity, had a direction in life, a positive vision for herself that she believed was attainable, and was in a supportive significant relationship:

I don't really have long periods of depression anymore. I feel like I know what I want, I know where I'm going, I have you know, this to look forward to, and you know, I know that I'm with somebody that I love.

Gwen measured her progress in her ability to function at work: “I do good now. My patience is longer than it used to be.” She described life in general according to her ability to handle it, and recognized pitfalls as normal. She also looked forward to better times:

But things are getting a little better. I have my days. They haven’t gotten to the point where I’ve had to call the 800 number, or run outside and cry, but you know, that’s just part of life’s tumbles, to take the good with the bad, and I have to say I’m in the middle. I’m good. I can handle it. Things are working pretty good for me. It’ll be even better once he gets a job.

Meg’s progress remained consistent over her interviews, however her interviews occurred closer together than most of the clients. She was able to rate her depression and both she and her spouse noticed the changes that occurred in her symptoms:

Meg: I guess on a scale of one to ten with ten being the best and one being the worst I’m probably just around a six right now, a six or seven. I’ve been much worse, but I have days when I feel stressed out too, so, I’m um, not doing wonderful, but I’m not doing nearly as bad as I was in the fall.

Researcher: What are you feeling good about that you are doing that helps to be up to that six or seven?

Meg: Well, I am able to actually be out and associate with other people without getting too bothered by that or feeling like, I don’t feel paranoid being around other people. So that’s been a definite improvement. I do get down about certain things. I dwell on things more than I should, just small things, but I’m actually able to be out and around others without feeling like I’ve done something wrong.

Spouse: Before you were hospitalized, you were very withdrawn and very reluctant to socialize with anybody, which was entirely uncharacteristic of her personality; but since hospitalization, since then I've seen pretty big improvement in all those areas.

Increase in Depression

Over the course of the research Mitchell's depression worsened as his circumstances worsened. He had begun to have suicidal thoughts:

And lately I been having the same feelings. I feel you know why is life worth it? What's it got to offer? For me it's a lot of pain and misery I put up with. I can't do half the things I want to do and that makes me sad. What have I got to look forward to? And you know the answer I come up with: nothing.

Confidence in Managing Depression

Positive Experiences

Participants varied in their confidence in managing their depression over time and according to their circumstances. Rachel had a confidence level of one of ten on entering the hospital with ten being able to manage her depression. When she was discharged it was a six or seven, however at the time of her first interview after continuing to experience depressive symptoms, it had dropped to a three. By the time of the focus group after she had gone back on an antidepressant and changed jobs to a more positive situation, it had risen to an eight.

Meg recognized that her confidence level increased after she was discharged. At the time of her hospitalization, she wasn't sure the treatment was helping her, but looking

back on it “then you think well maybe that was the best thing for me and the best treatment program.”

Julie recognized that her confidence level was influenced by what happened in her son’s life. Her confidence level dropped to a seven after receiving a letter from her son’s school putting him in in-school suspension. She also recognized, however, that she could manage her depression even when she was depressed from an incident with her son.

I had Andy put our steaks on last, so they were finished with their dinner, and we both could sit down and have an adult meal... after they got to bed, and it quietened down, I got to feeling a little bit better. Got up Monday morning and it was okay....It would be over a lot quicker if I had something to take, but like I told you, having to pop a pill every time I’m having a depression feeling or anxiety attack is not gonna fix the problem, so just work through it.

Participants’ experiences in success in one area of their lives appeared to help increase their sense of power to manage their emotional health. Charity described winning an oratorical contest even after developing laryngitis. She states, “Even though my body has been fragile, or my mind, whatever, I’ll always work with myself and get through it.” Karen described her reaction to learning to make goals for herself and following through on them:

Karen: I learned in the Rehab, they said to make goals for every day: just a simple thing as get up out of that bed and get your shower, take care of yourself, you know, don’t neglect yourself, and I did, that was my first thing. That was simple to other people but not to me because I didn’t even want to, but I made

myself do it and I felt like I had accomplished something and it helped me to do bigger things like get out there and reach out to people.

Researcher: When you did that goal, did that help your confidence?

Karen: Yes, yes.

Researcher: And how did that sense of power affect your depression?

Karen: I didn't feel helpless anymore. I felt like there was hope in spite of what other people did, as long as I didn't let myself down. When you feel helpless, it's depressing. When you feel like you have no hope, that's the worst thing.

Charity expressed a confidence not only in her own ability to manage her depressive symptoms, but also in the Holy Spirit: "I have learned that anytime I do something that is creating nervousness, I start talking to the Holy Spirit and inviting the Holy Spirit to take control."

Success influences not only a sense of power to manage one's emotional health, but one's very concept of identity. Gwen describes a complete change in self-perspective after experiencing success in one of her goals:

And then one day I looked up and I saw this shell, and I said I want that house, and I told Momma, 'Ain't nobody gonna give me that house. I don't have no credit.' Momma, said, 'Gwen, the least they can tell you is no, and you've heard it once in your life and you're gonna hear it again before you die.' She said, 'You won't never know until you go down there and ask.' I went down. I told them people what I wanted. I gave them all my history, and I had just gotten out of treatment that July. November that same year I was moving in. So, with

that I knew Gwen you can do anything you want to do, anything, even stop drinking.

Gwen has since used that newfound confidence in her abilities at work, where she faces language barriers supervising a line of mostly Spanish speaking workers.

I actually went out and bought myself a Spanish book. A couple cussed me out a couple of nights. They were calling me pudda, and I went to the one that said it and I said, well if you gonna call me pudda, you call me Miss Pudda, cause they were calling me a bitch. So, he looked at me, eyes got all wide. I smiled and he smiled back, so everything was okay there, but I knew that he knew that I knew what he had said.

Ben also learned that he could help himself emotionally. By getting off and staying off drugs even when depressed, he became proud of himself:

I am so proud of me. It just makes me feel so good that when I'm that down and out I still don't turn to drugs.... It was a good high for me...to know that I've made it...without doing stuff. I've made it! Yourself can make you higher than anything ever will.

Negative Experiences

Not all patients experienced success in managing their depression, and some had times when they felt successful and times when they didn't. In response to a question about how she had managed her depression Charity, who generally saw herself as successful, replied:

I haven't been managing it. I have not been managing it very well. Cause I've sat in here and cried. Looks like water just keep running out of your face,

and I think a lot of thoughts that, of being by myself. Just stay depressed, I know its depression, cause I really don't know nothing what I'm crying about, other than just being sad.

Although Mitchell never directly talked about his confidence in managing his depression, during the interview where he was significantly more depressed, he made several statements of powerlessness. He talked about losing his finger and stated, "There's nothing I can do about it". He talked about his neighbor committing suicide, and stated, "There was nothing I could do to stop that." He talked about trying to get his family to help him and commented, "I can't make no moves till they do, and I can't make em do it. They do it in their own sweet time."

Summary of Views of Depression, Progress, and Confidence

In describing their depression, all participants except for two categorized their depression as long term and chronic. On entering the hospital, the majority of participants recognized their symptoms as depression. They described their depression in terms of a loss of self or as uncharacteristic of their personalities. They recognized that their depression was either influenced negatively by relationships with others or had a negative influence on others. They understood that their depression often fluctuated in degree and that there were multiple causes that contributed to its development. Most accepted their depression and tried to cope with it. They varied in how they viewed their ability to handle it. Some saw their depressive feelings as manageable, and became active participants in taking responsibility for their own healing. Others felt helpless to manage their depressive feelings, seeing themselves lacking motivation and power to act.

In spite of those feelings of helplessness, the majority of participants improved over time. They did not see themselves as free of depression, but they did see themselves as better. They recognized their progress by knowing the particular symptoms that had characterized their respective illnesses and monitoring any changes in those symptoms. They also measured their ability to function, such as in basic activities of daily living, ability to socialize, and ability to work effectively. They identified the circumstances that had changed positively in their lives. They had a sense of direction about their lives and experienced loving relationships.

All six of the patients who were on medication improved, however it often took several months and medication was only one of the factors influencing their improvement. Three of those who were not on medication improved. Each of these three persons was highly motivated to get better and had a strong sense of self-efficacy. In spite of improvement, one recognized that he needed to be on medication and was willing to see someone for it. One participant who was not on medication did not improve, but rather worsened over time. He recognized the need to be on medication, but attributed his lack of progress to his circumstances.

Participants who saw themselves improving had better self-esteem and hope for the future. They generally had stopped isolating and sought support from others. They were active in caring for their depression. They had a vision for the future that was increasingly positive.

The participant whose depression worsened had low self-esteem, multiple losses, increased pain and health problems, feelings of helplessness and powerlessness to change

his circumstances, and no positive vision for the future. He saw himself as dependent on others who were unwilling to help.

Most of the participants except for the one whose depression worsened expressed some sense of confidence in their ability to manage their depression. The one whose depression worsened saw himself as helpless and attributed his depression to circumstances beyond his control.

Others recognized that their confidence level varied over time depending on their degree of depression and on what happens in the circumstances that usually impact their depression. How they responded to those circumstances also influenced their confidence level. In addition, they were able to use a success experience in any area of their lives and apply that resultant confidence to their ability to manage their emotional health. They based their confidence on their own behavior and not on someone else's; however, many expressed a spirituality that essentially was a form of confidence in a higher power available to help them manage their depressive symptoms. Lastly, their very experience of success influenced not only their emotional health, but also their self-image, which helped enable them to act on their dreams.

WAYS PARTICIPANTS MANAGED THEIR MENTAL HEALTH

Strategies and Conditions Promoting Mental Health

Although there are environmental factors that promote mental health, such as the availability and quality of resources, the purpose of this research was to focus on how participants have managed their mental health and what role relationships have played in depression management. Every participant used multiple mental health strategies, which

were grouped into five general categories: knowledge, self-efficacy, action, voice, and relationships.

Knowledge

Self Knowledge

How people define themselves and what they know about themselves influences how they respond to depression. Mitchell described himself in a manner that required him to persevere:

I'm too stubborn to give up... Some people think I'm down, and then you can walk around stomping on people. But they better be careful, cause I ain't six feet under yet. I do have this nasty habit of reaching up and grabbing that rope and pulling myself up.

Julie defined herself as a non-depressed person and then when she behaved in a way that is different from that image, she corrected the behavior.

If I walk across the linoleum, granted, it's just swept, but if I walk across the linoleum in bare feet and I can feel stuff on my feet, it drives me crazy. But I know that when I walk across the same floor and its still there and it doesn't drive me crazy, I know I'm depressed...I'm not the type of person to put on a pair of socks or shoes or slippers to override that feeling, cause I know its still there, cause I've already felt it on my feet, so let's go ahead and clean it up and get it over with.

Skills

Many participants talked about the importance of learning patterns as a way of helping themselves get better. Charity described using “methods” to help her cope with the anxiety that often accompanied her depression:

Charity: I was so nervous that I had to learn me a pattern to get to my room. And I would walk against the wall, and as long as I was touching the wall, I could make it.

Researcher: What did the sense of touch do for you?

Charity: Gave me peace. Just relaxed me.

Researcher: It grounded you.

Charity: Uh huh, it certainly did.

Julie also actively sought to learn skills that worked:

Just realizing your alternatives and what alternatives work best, trial and error. And then what works stick with it, and if that doesn't work, learn to try something else.

Ben credited learning to think ahead with helping him to change behaviors that fed into his depression:

I've learned something. You show somebody respect and they show it back to you... I've finally, I've learned to think before I speak and before I do. It works so much better. I mean, I can think all I want to after I do something but that's not going to help me none.

Past Experiences

Several participants used what they have learned from their past experiences to help them change. In response to a question about what factors help her manage her depression Julie replied:

Past experiences and knowing how you failed last time, and knowing you can't make that mistake again... not making that same decision over and over, because that's the wrong decision, learning how to make the right one, and knowing how to get there and do that.

Rachel also learned from her past experience. As the major financial supporter of her family, Rachel forced herself to go to work even when she did not feel like it. Because she had difficulty functioning in the morning, she took a job working at night. She learned by experience that she can work through her pain:

A lot of mornings I wake up and I'm still tired and I want to sleep more, but it just hurts laying in bed. I have to get up and move around. I used to think when you hurt more you know you need to take pain medicine, but mine eases up and starts getting better if I get up and start moving around and get active.

Perspective

Julie learned to put things in perspective as a way of helping herself. She differentiated between reacting to situations and responding to them by “being aware of the whole situation, what makes you feel this way, why it makes you feel this way, what happens if you manifest on it versus overcoming.”

Self-Help Books

Several of the participants used self-help books to enable them to work on problems. Julie used The Anxiety and Phobia Workbook and described it as “an open door for it all” in referring to depression management. Gwen used Self-Esteem when she found herself starting to get depressed:

Before it gets really hard on me, I’ll sit down and pick it up and relax myself and read. I like it, it’s uh, straight to the point, even though it might be dry, to me it’s knocking right at my door.

Self-Efficacy

Self-efficacy, which is a “belief in one’s capabilities to organize and execute the courses of action required to produce given attainments”, (Bandura, 1997, p. 3), is related to several factors. Four factors are goals, effort, perseverance, and beliefs. In talking with the participants about depression management, three factors related to self-efficacy emerged: motivation, belief, and vigilance.

Motivation

Desire for Health

To monitor her depressive behaviors, Julie stated that in order to change them, “you have to have the want, the desire, the care to do it”.

Ben has a dual diagnosis of depression and substance abuse. Much of what he learned about relapse prevention came from his experience of getting off of and staying off of drugs. Like Julie, he saw the most important part of relapse prevention to be motivation:

I can’t express that enough. You got to want to do it. You

got to want to do it. Nobody can make you do it. You have to do it for yourself. The key thing to quitting and everything and changing and everything is wanting to do it. You have to find the piece of it that's inside of you and everybody has it.

Exercising Choice and Taking Control

Ben understood that he had a choice in what he did to help himself.

I always let people tell me that you can't control yourself sometimes, which is wrong. You can always control yourself. You always got a choice...you can make a choice to think or not and what you have to teach yourself to do is to think before you act.

Rachel also thought that taking control was one of the most important factors in depression management. She clearly believed she could change her emotions:

Learn how to take a little control over your emotions, instead of letting your emotions and everything control you...Just when you're in that dark, funky place, you start thinking about good things, or go out and do something to make you feel better, and you get out of it.

Valuing Self and Others

Several participants understood how their value of others or themselves influenced their motivation. Mitchell identified a love for his mother as part of the reason he did not attempt suicide. When asked how she kept herself from getting too low, Gwen credited her love for her mother and said, "I am going to do everything I humanly possibly can for her." She then went on to say, however, that it was not because her Mom needed her, but rather "I need me. That's my biggest one. If I don't take care of me, nobody else will, and that I know."

Goals

Julie kept a clear picture of the goals that she had set for herself, and which she believed helped her in the long run. The goals motivated her to tolerate the emotional discomfort that sometimes accompanied carrying them out. She illustrated this in a conversation about delayed gratification with her children:

Right now Momma has, we have to worry about school, so if you want to be able to do these things, I've got to finish school so I can get a good job, so it'll be us, so we can do it. Sacrifice now for something better later.

Fear

In addition to positive motivations, there were negative motivations. Meg was motivated to work on her depression partially because she did not want to be readmitted to the hospital: "I don't want to have to come back to the hospital again, so I'm trying." Mitchell freely admitted that fear of the consequences kept him from attempting suicide: "scared of what might happen".

Vigilance

Several participants described coping with depression as an ongoing process. In order to manage it they vigilantly monitored their symptoms and progress. Gwen described herself as in charge when she monitors her symptoms:

But sometimes things get a little heavy, but I don't let things get to the point to where I just gonna throw up my hands and say, 'Forget it, I give up, I don't want nothing to do with nothing.' I can't let myself get that low.

Julie connected her vigilant response to symptoms of depression with an understanding of the potential consequences if she ignores them:

I beat myself up and make sure I go back and fix it, cause if I don't, it's gonna compound and snowball and I'm gonna be right back in the same cockeye that I just came out of.

Charity described a perseverance of pushing to do things to help herself in spite of how she felt:

Charity: The preacher wanted to go to a meeting in Florida, and he called me and asked me if I would take the service Sunday, and I told him yes. Then I wanted to call him back and say, 'No, I don't think I will.' But I didn't, and I was glad.

Researcher: What kept you from saying no?

Charity: It was me, saying to my own self, 'You got to go because if you don't go you will never go.' So I just pushed it...I was letting something make me not go, just my thinking, I guess. I'm just gonna keep pushing. I'm not gonna sit this out. Just go anyway.

Belief

By their actions and by their words, several participants demonstrated a belief in their capacity to change. In order to move forward, Karen had to let go of parts of the past that were unhelpful to her. She expressed her belief in her capacity to change in talking about her relationship with her husband:

I look at this as a new beginning. I look at those years before he left as that of the past, it's over and done with...you do change...I feel like we're changing together and it's a positive change.

Ben also expressed hope for himself and a belief in his capacity to change when he talked about not going back to using drugs: “I won’t go back on it. I ain’t going on it. I got too much high hopes for myself.”

Action

Taking action involves using both cognitive and behavioral techniques to manage depression. These are what we often think of as the therapeutic strategies that therapists encourage clients to use.

Cognitive Strategies

Thought Stopping and Refocusing

Gloria identified the things she did that were unhelpful for her mental health, which usually involved rumination, and she used thought stopping, then refocusing to assist her:

But I try to say, like do the thought stopping thing in my mind, saying, ‘Shut up Gloria, you’ve already gone over that a hundred times. I’m ruminating.’ It does help, or I try to get my mind focused on something like, I have a lot of interesting books that I want to read.”

Reflection

In addition to thought stopping, Karen used reflection to help her process her behavior:

“I think it’s just that I had a lot of time on my hands and I had a lot of time to think...I thought about the things that I did and the things that I didn’t do. I realized that I don’t want to do those things anymore.

Visioning

A third method of cognitive strategies involved the use of visioning, or focusing in time frames. Gloria, for example, talked about staying focused on the present and trying “to face reality”. She acknowledged that:

I have such difficulty...letting go of the past just because it's with me all the time, and I have this long- term memory. I remember things so clearly, and detailed, as if they happened yesterday.

Ben, on the other hand, faced a very difficult present, so he focused on the future. He repeatedly emphasized, “I'm not focused on going to jail, I'm focused on getting out of jail.” He tried to look beyond the experience to a more positive future. He made plans to enroll in the local community college once he was released, and he talked with his mother a lot about setting up his own business once he had his degree.

Gwen also had a positive vision of who she was and who she could be that motivated her: “I got back up on my feet. I saw what I could do, what I could be, what a beautiful person I am, and I don't want to ever lose that again.”

Imagination is a different type of visioning, which Mitchell used to help him deal with his circumstances:

Mitchell: I can act crazy. When I was in the hospital, I just pretended I was a duck and could go home. Heard of super duck? Quack, quack, I was super duck. I used to hide a lot of my pain. I figured ‘Well, hell I can't do what I want humanly, I'll put it off on an imaginary character.’ (Laughs)

Writing

Gloria had a lot of painful feelings about her relationship with her daughter, and she planned to use her writing skills to “write about my relationship with her from day one, and it’s all going to be positive and upbeat.” She planned to give her writing to her daughter “as a way of helping her have a different perspective on things.”

Dream Analysis

Gloria had one slightly unique method from her training as a psychiatric nurse that she used to help herself come to resolution with the things that contribute to her depression:

I have happy dreams. I analyze my dreams. I studied dream analysis, and I kept a dream diary for a while, and I understand what my dreams are about. And of course it’s mostly wish fulfillment, wanting to be loved and have the people I love in my life. I just dream about people, and my daughter.

Behavioral Strategies

Self Reward

Julie used a reward system to help motivate herself: “If you do x amount of chores, you can do x amount of this, like reading in my book.”

Time Out

She also used “time out” to manage her emotions. When visiting her father, she offered to go and buy his groceries rather than stay and argue with him. When she came back they were both cooler and let the argument drop.

Julie: You can sit here and fight and hate each other for five minutes and leave and never talk to him for another year, or go to the store and come back like he'd never say a thing about it.

Involvement in Activities

One of the most common methods of depression management was simply staying busy. Charity shared about a conversation she had with one of her doctors earlier in her life that helped her:

One of the things he told me was that I had to just do what I've done, like go ahead and do what you're doing: work. I got a job. That was after I quit teaching. I worked in the upholstery shop for about five years.

Gwen also used action to help her cope with her depressive feelings: "I get busy. I clean house. I'll work from sunup to sundown to keep my mind off of where I could end up."

Meg had a variety of ways she stayed busy, but she also recognized the downside of staying too busy:

If I keep busy then I don't seem to get as depressed. If I don't have much to do then I get more depressed... Sometimes I feel like I'm under more stress, but I'm not getting as down and depressed.

Time for Fun

Rachel recognized the importance of taking time for fun in her life. She stated that during the summer when she and her family took a vacation at the beach, she was unaware of the black hole of depression.

Medication

Those participants who were on medication recognized the importance of their medication in helping them manage their emotional health. Charity credited her medication with enabling her to function all her life. Gwen credited her antidepressant with helping her to be able to manage a very stressful job.

Voice

The importance of using one's voice was expressed by almost all of the participants.

Self-Talk

There were many uses of self-talk. Julie frequently used self-talk to reassure and encourage herself: "It'll be all right. It'll be okay." Gloria used self-talk to remove negative labels and give herself a positive label. She called herself an "overcomer" rather than a "survivor". Ben used self-talk to challenge himself. When asked what enabled him to think first he stated,

I guess it might be getting off drugs, either that or just maturing and actually telling myself to do something with my life and don't lay around and be a bum your whole life and a druggie your whole life.

Gwen used self-talk to vent her feelings. She either talked to herself or to someone else.

I vent a little bit, and the majority of the time, it's on Charles. The rest of the time, I stuff. I just stuff. I find myself at work and even at home talking to myself. And it's never nothing positive. I mean it's always, where something done ticked me off, seems like everything comes up. I feel like if I can get it out,

and not stuff it, I'm okay, because I feel like if I keep on stuffing it, then one day it's going to explode.

Speaking Out

In addition to speaking to themselves, participants learned to speak out to others.

Karen understood the importance of expressing her feelings:

I don't feel like I have long periods of depression. If I have someone that will listen to me and I can talk it out, it doesn't last long... It used to be that when I had a problem he would get up and leave the room. It's like, 'I don't care to hear you and this is my way of showing you this.' Now he will sit down and listen and not say a word, and usually that's all it takes... I don't need him to offer any solutions...you know, it's not a question of who's right or wrong; it's just, 'please understand how I feel.'

When Julie started to feel depressed, she relied on her friends to allow her to express her feelings. She associated not talking with losing her self-management:

You can feel it when it's starting to set in...When I get to feeling bad I get on the phone, I'm like, 'You got to talk me through this,' and then I can handle it okay. I'm not wallowing in it anymore...if I feel it seeping in, I talk to somebody, cause if I don't talk, then it's going to jellyroll me. It's going to wrap me up and...

Ben's mother began speaking out her feelings to Ben, and in doing so redefined their roles and relationship.

And you know, it's just I hate to see my child go to jail, cause I know him. He's not a bad kid. I told him, 'Ben, I don't have to be the strong person anymore.'

You're a grown man. I don't have to be strong and fight ya'll's fights anymore.' I said, 'I can feel the emotions I need to feel now', and I said, 'That hurts.' And I feel like he needs to know it hurts. I'm Mom. That's my job. But like I told him, I can say, 'You make me mad.' But, I mean Ben, like I said I'm real proud of him now, he does so well. And this is just a speed bump right now.

Speaking out was not always verbal. Karen wrote a letter to her spouse's ex-girlfriend when the girlfriend was still trying to get him back:

Finally, I decided I had had enough and I was not going to tolerate this anymore so I wrote her a 14 page letter and I told her just what I thought and how I felt... I have felt good ever since.

Relationships

Relationships compose a key concept in depression management and are dealt with more thoroughly in Research Question 4, however as a part of depression management, I am also including some aspects here.

Socialization

Depression is an isolating illness and isolation worsens depression. The participants understood the need to have contact with others.

Karen consciously decided when she left the Rehab that she needed to be with other people:

I thought the worst thing for me right now is to be alone, so I started reaching out to people. I don't think there is a day that went by that I was alone. I said, 'I don't want to be alone. If I'm alone I'm going to sit and dwell on what is and what isn't and what could have been or what I should have done.'"

Commonalities

Meg also recognized the importance of reaching out to friends, however what was important to her was the understanding that others shared her experiences:

Just talking to others sometimes helps. Talk to other people and find out that they worry about little things too. I'm not the only one that worries. I think opening up to others and finding out how they've dealt with things is a plus, especially is you talk with someone who's had more experience on that particular issue than you have.

Support

Ben relied on his friends for support. He was comforted that while he was in jail, his best friend would come down to the house to split wood for his mother.

Mitchell also relied on his friends for support, and like Ben, he thinks of support as active help. "I'd like for that girl to call me. If she calls me and says 'I want to help you', I'll say, 'Good, come up and do it.' (Laughs) 'Quit talking about it and do it.'"

Caring

Julie understood the importance of talking, and identified caring as a major component of relationships:

I call my best friend that I've had since high school. I mean we call each other sister. She has a point of view, I laugh at her, and I tell her, "You sound like Mom sometimes," and she says, "Well, it's cause I love you and I care." You only get that kind of reasoning and judgment from somebody that really cares.

Helping Others

Ben identified helping others as something that also helped him to feel better:

If you go out in the world and start working and helping people, that's something else that gives you a high you wouldn't believe." He took great pride in helping his best friend to change:

I love the fact that...I've seen a big change in his life since the first day I met him. He's kind of learned from my mistakes, and I'm so glad. That makes me happier than anything.

Listening to Self

One of the important relationships that participants verbalized is the relationship they have with themselves. Karen found it important to take time to listen inside herself and in doing so she began to redefine how she thought about death, and that helped lessen her depression. She made a conscious choice how she would view things, and she recognized she could change her thinking:

I've learned that although they're gone, they're really not gone, because there's a little bit of both of them in me. I'm not going to look at it as that final. I believe they're in Heaven. I don't believe once they die it's over and done with.

Self Acceptance and Forgiveness

Karen found new freedom in allowing herself to be human and forgiving herself and others:

I used to be a perfectionist and think that I had to be just right. I realized I was human and accepting that was great. It's like, 'Okay you're human, you make mistakes, get on with it. If God can forgive you, you need to forgive yourself. You're not perfect but he is'... And if you can't forgive yourself, how

can you move on? Forgiveness is real hard, but I can forgive. If he can forgive me and remembering what I've done, who am I not to be able to forgive him?

Self-Time

Julie credited “self-time” with helping her to get better. She intentionally made time to be alone to accomplish her goals for herself.

I find that I need more and more time to myself. I think I'm shorting the kid's (tearful voice), but in retrospect if I don't feel better, it's not going to do me any good. So I am sacrificing.

Summary of Factors That Promote Mental Health

Although each of the participants described what worked for them in their own language, they each touched on common themes.

Many of them emphasized the importance of understanding not only their disease, but also their personal symptoms. They were vigilant in monitoring those symptoms and took action if they saw them increasing.

Several of the participants either directly or indirectly expressed how important motivation was in helping them to manage their depression. They used words such as “will,” “want,” “desire,” “care,” and “heart” to describe what they felt inside themselves that kept them going. Motivation appeared to come from a variety of sources, but one source was that several of the participants kept before them a very clear picture of what would happen if they did not act to manage their depression.

The participants emphasized the importance of knowledge. They had learned from their experience and used that information to both motivate and guide them to the

future they wanted. If they did not have the knowledge they needed to help themselves, they actively sought it, such as through self-help books.

Those participants who were active in their depression management took responsibility for behavior changes, and they expressed a confidence that they could make a difference in helping themselves. They believed that change was possible. They did not let their feelings control their behaviors, but rather “pushed” themselves to behave in healthy ways in spite of their feelings. These behaviors were the “methods” that they used to promote their mental health. The methods often varied with the background and interest of the participant. Many of them, however, mentioned the use of thought-stopping, self-talk, and staying busy.

They used their sense of time and vision to manage feelings. If the past was depressing, they focused on the present. If the present was unpleasant, they looked beyond to what could be.

The participants also valued themselves. They often equated depression with a loss of self, and part of their motivation to manage their depression was their desire not to lose themselves again. They worked at accepting themselves, forgiving themselves and others, taking time for themselves, setting goals for themselves, rewarding themselves, affirming themselves, encouraging themselves, listening to themselves, and allowing themselves to have fun.

Several participants emphasized the importance of using their voice to speak out to get better. They needed to talk with others, and they needed to talk to themselves. They stated they felt better when they expressed what was inside of them, and they no

longer felt alone when they knew that others understood or had experienced what they were going through.

Strategies and Conditions Inhibiting Mental Health

Isolation

Involuntary

One of the most poignant and consistent themes that participants verbalized over and over again in their stories was the concept of aloneness or isolation. Usually participants felt alone through no choice of their own. Gloria described several traumatic times in her life when she went through difficult experiences by herself:

I went and got the divorce. I was there all by myself, nobody was with me, and I walked in there and got my divorce, and when I walked out of there, I felt like my whole world had just come right down on me, and I must have looked horrible, because when I got on the elevator, people were just looking at me really strangely, like ‘What’s wrong with you lady’, but my whole world had just collapsed.

Mitchell describes his aloneness as actually losing his children:

Mitchell: I mean I lost four.

Researcher: Four what?

Mitchell: Kids.

Researcher: But you haven’t lost them.

Mitchell: Yeah I have.

Researcher: How would you know if, what would tell you that they did care?

Mitchell: They’d come and visit a little more, and just talk.

When Gwen describes her relationship with her father after he remarried, she describes it in terms of loss of the family:

He's with her and her family and as far as we're concerned he don't have a family anymore. He don't come around. He don't call. I mean if he was interested, he could call while he was at work. He still works and he works daylight, and he knows my number, and he never calls, never comes on his lunch break. So, he want to be free. He's free.

Voluntary

Although participants often felt involuntarily isolated, occasionally they chose isolation. In most cases, this was also unhelpful. Ben, who was depressed in his first interview, described an intentional isolation process to prepare himself for jail. He describes his experience as “going out of his heart”, which appears to imply a separation from self:

I've already started getting prepared to go to prison though. I've already prepared myself to go out of my heart. I'm already starting the stages of kindly separating from people I love and to not be so devastating. It's going to be devastating and it's going to send me back into a depression. If I'm already slowly pushing myself away from them and not quitting them cold turkey and not quitting them completely, it's easier on me.

Gwen has also intentionally isolated herself from others: “As far as friends, I don't have any. I used to until I saw the true them, and so, you know, I'm mainly a loner.”

Pain

Physical

Pain was a stressor for several participants that appeared to hinder their progress in recovery. Pain could be either physical or emotional, however several of the participants in the research coped with physical as well as emotional pain. Gloria's description of her pain came out as a desperate cry:

I mean I'm having all this pain in my spine, my legs, and my feet, and my ankles swell up like a balloon, like they are right now; and you know, how much can one person take? I mean it just goes on and on and on.

In response to a question about his pain, Mitchell described it and then began to talk about suicide:

Varies from day to day. I don't know what I'm going to face when I wake up every day. It do scare me at times. And sometimes I don't know what I want. I could do it. I don't need no gun, I don't need no rope, just do it myself.

Emotional

Ben expressed his concern for his mother's emotional pain when he talked about going back to jail: "I don't look forward to going back. It's hard on me and it's even harder on my mother. I think she's gonna take most of the pain."

Losses

Death

Almost all of the participants in the research had experienced some kind of loss. Many had depression that began following the death of someone they were close to: Ben's father committed suicide in front of him when he was a child. Months prior to his

hospital admission, his grandmother and his uncle died within two months of each other. Ben's mother describes his reaction in terms that indicates he was losing part of himself:

It grates his heart. It's real hard, and what I've always tried to tell Ben, 'You got to find a place in your heart, you know, and go visit it, but you can't dwell on it, cause it will eat you alive,' and that's what he was letting it do was eat him alive. But he's got to find a place in his heart and visit it, like I said, but don't visit it till when it depresses you. When it starts that, walk away from it and go back. It's just something you do, you just learn. You just, you know, it's grief. Grief's been real hard.

Karen became depressed after the death of her mother and developed major depression after the death of her father two and a half years later. She described her reaction essentially as a loss of part of herself:

It felt like my entire past was gone because those two represented my beginning and a big part of my past...and when he died it seemed like it was more final that my mom was gone.

Anticipatory Grieving

Two participants appeared to have anticipatory grieving associated with nursing home placement and an upcoming loss. Gwen had watched her mother's health go downhill until she had to admit her to a nursing home. Charity had admitted her spouse to a nursing home and became increasingly depressed when he deteriorated.

Physical Functioning

Not all losses were terminal. Five patients had significant health problems that restricted their ability to function.

Abandonment

Some participants did not grieve over the death of their families, but rather over a sense of loss of contact or actual abandonment. Gwen described her perplexity at the behavior of her family, who do not visit or call her mother, in terms of an incurable disease:

And I can't understand why they can't take five minutes: 'Hey Mom, how you doing? I did such and such today'... They're my family. I love my family, but this pitch I got, I hate it. I don't think I'll ever recover from it.

Charity refers to a recent job transfer of her daughter to Philadelphia, whose son she babysat for daily, in the same terms that Ben's mother used to describe his grief:

"That did bother me more than I thought. Ate me up."

Work

Mitchell expressed a sense of loss at being unable to work. Ben also identified work as being a major contributor to his depression.

Loss of ability to drive

Both Mitchell and Ben identified not having a driver's license as a contributor to their depression.

Stressors

Some stressors that participants experienced were chronic and long term. Julie referred to the problems with her son, who has ADHD, as being her major trigger for relapse: "It's almost like it doesn't do me any good to get away and de-stress to come back and within an hour it's all started up again." Although Julie normally expresses a

sense of self-efficacy in her ability to handle things, when she talks about her son, she expresses feelings of powerlessness:

Well, I had em Sunday. I mean we had to go and pick all the kids up, and it even started before I got there to pick him up. I called...and he was already shooting his mouth off and I'm like 'I have to go and hear this'. And I started coming down.

Gloria described the experience of caring for her sick husband: "But it was like hell on earth, being in this horrible little apartment and waiting on him hand and foot and just watching him die." She now has her own stressors of financial and health problems in addition to her previous stressors contributing to her depression.

Charity described her stressors as a "multiplicity" of things, which all happened at about the same time.

Denial of Voice

When participants are not free to talk, they become "unknown." Gloria recounted an incident with her daughter where she felt silenced and its effect on her:

I was trying to talk to my daughter one time about my life as a nurse, and I started telling her about one of my patients, and she didn't want to hear it. She said, 'I don't want to hear about that. That's disgusting.' So I feel now she doesn't know me.

Rachel also expressed her aggravation at her husband's presumption that he knows her when she doesn't even know herself:

Sometimes I get aggravated like if I try to talk to him or something. I mean I don't even know what and how I feel, and he sits there and tries to tell me

what and how I feel. Even if I told him, he probably wouldn't listen, because I can try to tell him something, and I'll be in the middle of a sentence or whatever, and he just starts talking to me about something totally different.

Negative Voice

Although denial of voice is a problem, negative voice is also a problem. Mitchell used negative voice when he labeled himself as a "complete idiot. I'm a complete idiot. That's my impression of myself."

THE IMPACT OF RELATIONSHIPS ON DEPRESSION MANAGEMENT

Participants described three relationships that were important in depression management: their relationship with self, their relationship with significant others, and their relationship with God.

Relationship with self

Several participants recognized the importance of having a good relationship with themselves in order to promote healing. Gloria recognized the importance of a relationship with herself in managing her depression, however in her comments about self-esteem, she implies that her depression is bigger than her self-esteem:

I've had counselors tell me 'create a new self'. No, I'm not going to create a new one, cause the old one is plenty good enough for me. (Laughs) I mean I have good self-esteem, I really do. And I am my own best friend, and I'm very comfortable in my own skin

Gloria actually defined herself in terms of her relationships: "To me the greatest thing on earth is other people. And that's the only way you can know who you are, by how you relate to others.

Ben used his definition of himself to help him quit his drug use: “I decided in my heart and in my mind...I said, ’You know, I woke up one morning and said, “Ben, this ain’t you.”

In contrast to Gloria’s belief that she knows who she is through relationships, Ben had a need to isolate from other people, specifically girlfriends, in order to know himself:

I told them this the other day: ‘I’ll call you all when I’m ready.’ Let me find me. I haven’t known me for a couple of years. Can I find me before I know you all? I need to find out who I am first, you know.

Gwen also had a healthy understanding of the importance of self and identified relapse with loss of self. Her main motive for relapse prevention was the knowledge that: “I’ve got too much to lose to pick up, too much to lose, because I be losing me.” In another statement she connects losing herself with not wanting to live anymore, a major symptom of depression:

I worked so hard to keep it, and then, at a slip I don lost it all. So I wouldn’t even want to exist anymore. And like I said, I love me. I got back up on my feet. I saw what I could do, what I could be, what a beautiful person I am, and I don’t ever want to lose that again.

In contrast to participants who were expressing positive things about themselves, Mitchell had negative labels for himself. In commenting about his family in his first interview he stated:

To them I’m important. How come I’m not important to myself? That’s a question I can’t find an answer to. The only thing I know that I do is provide myself a lot of misery.

It is interesting to note that he was also the most seriously depressed participant.

Relationship with Significant Others

As the participants described the relationships in their lives, it was clear that many of these relationships had significantly impacted their mental health. This section focuses on those participants whose significant others actually came to an interview. In all interviews, participants described how significant others impacted their mental health, but in the conjoint interviews, they demonstrated it.

David and his spouse both dealt with depression. When asked how one's depression impacted the other, they answered:

Wife: Well, uh, when he's depressed, if I'm not, it doesn't bother me, because I know I try to deal with him and help him. I try to deal with him.

Researcher: So it doesn't get you depressed?

Wife: No, it doesn't get me depressed, but I don't know how he feels.

Researcher: How do you feel about it?

David: Well, it don't get me depressed. I just want to get her out and get her somewhere or another.

As stated earlier, Meg's spouse was very supportive. George felt free to give Meg feedback when he saw her exhibiting depressive behaviors:

George: I'll say "Meg that's just paranoia coming out. No one is really doing this to you. That's just pure paranoia, which is part of depression."

Researcher: Now how do you react when he does that?

Meg: At the time when he said that, sometimes I think he's right, or if I feel overwhelmed prior to my hospitalization when this happened, I guess I wasn't sure whether to believe what he was saying or to continue to feel the way I felt.

Researcher: So he was asking you to go against what was reality for you, and reality was based on your feelings, and he was giving you an intellectual, and there's nothing wrong with that. But you're not feeling, and so you're coming from a thought process.

Meg and George: Right

Meg: And when you actually feel that yourself,

George: you don't believe what somebody is telling you.

Meg: it kind of takes over everything.

Ben had a very special relationship with his mother, who frequently used healing language to encourage him. Ben described the relationship as special for him because of her unconditional love:

Me and my Mom have an unconditional love that's unbreakable. It might as well be my heart. She always has been my most inspiration. I would go out here and blow the world up and mom would still turn around and tell somebody she loved me and still don't think bad of me. She'd be disappointed in me but she would still help me to do better though.

Ben stated that the only thing he feared from his mother was abandonment:

The main thing I fear with my mother and stuff is I don't ever want her, which I know she wouldn't ever turn her back on me, but the two things I hate the worst is making her cry and making her disappointed in me.

Ben's mother demonstrated her encouragement of her son and her vision for him several times in the interview:

That's what I was telling Ben. He talks about having his own business, which he can do cause he's smart enough to do it. I said, 'Maybe you can get kids like you, and bring em in here and show em somebody cares, so they don't have to be out here on the streets and getting into the trouble he's gotten.'

Relationship with God

In addition to relationships with themselves and with others, several participants gave credit to their faith in God to help them improve their mental health.

As he was facing prison, Ben expressed his belief in God's support:

Even if I go He'll be there with me, you know, cause I know He'll follow you anywhere you go. He'll go with you: jail, prison, anywhere. I know if I go He'll help me through it.

Charity also depended on her faith to help herself:

I guess the first thing that has helped, and I've been in it all my life, is being a Christian, and knowing that God did make promises, and He will not let us down, if we will just lean on Him. That's my major thing.

PARTICIPANT SUGGESTIONS FOR MENTAL HEALTH TREATMENT

Experience in and Suggestions for the Rehabilitation Center

Overall, the participants described a very positive experience in the Rehabilitation Center.

Helpful Roommates

Karen was very appreciative of her roommate, who helped her to realize she was

not alone:

My roommate was a real asset to helping me. She pulled me out of the need to isolate and to go into a shell and the next thing you know we're talking and laughing, like, you know, it's a sleepover or camp...It's just that, hey, there's somebody in here that's going through something like me, and if she can laugh, I can laugh.

Frequent Contact with Caring Staff

She also appreciated the staff, who didn't leave her alone. She stated she began to feel like somebody cared, and "I felt like the people were genuine."

Need for Follow-up Contact

Nevertheless, she described leaving in phrases that indicated how vulnerable and alone she felt:

It's like turning your child loose. 'Okay, don't go out in the road', and then you open the door and you turn your back and who knows if they go out in the road and get hit by a car or whatever.'

Staff Who Help You Increase Your Self-Esteem

Ben had difficulty being in the intensive treatment unit when he first arrived, stating that he felt the isolation made him "even more suicidal", however, he developed relationships with the staff that helped him feel better about himself.

I would come up there. I'd cut up and carry on with them...because them people would laugh back with me and joke with me, they made me feel so much better about myself.

Improve Groups

Like Karen, Charity “felt like I was leaving too soon.” Charity did have some constructive criticisms of the program. She had been in a previous program and was able to compare the two of them. She felt that the group leaders were not adequately prepared and they didn’t really teach their material. She would have preferred smaller groups with participants with more similar diagnoses grouped together. She saw the information taught as “too general and not specific.” She recommended using role-play techniques to help participants learn new skills.

Unlock Doors

Meg and her spouse both felt she benefited from her time in the Rehab; however, Meg had difficulty with some of the rules: “I think it’s somewhat demeaning... to be behind locked doors and not be able to get out at your free will.”

Increase Doctor/Family Contact

Meg’s husband expressed frustration with the lack of contact by an attending physician and again a sense of isolation:

To be secure and to feel like the hospital had a firm grasp on whatever was going on, I wanted the attending to pick up the phone and call. That didn’t happen unless I asked for a physician to call me...I know they’re busy, they’ve got other patients. I only have one wife...I just felt like sometimes, ‘Gosh, evidently we’re just out here on our own.’

Schedule Quicker Follow-Up

Rachel was in the Rehab twice within a month. Her major recommendation focused on timing of follow-up:

They need to try to get that first contact with them like within seventy-two hours after you get out of the hospital...If they can't get you set up with the CSB any sooner than they can; they give you an appointment maybe three to four weeks out, then they need to have something for you to go to in the meantime.

Experience in and Suggestions for Outpatient Therapy

In describing what they wished to experience in outpatient therapy, the participants mentioned several basic therapeutic skills.

Support Group

The primary suggestion for outpatient therapy was to set up a support group for people who have been discharged from the Rehab that meets weekly. Several participants chose not to attend outpatient therapy. The most frequent reason given for no follow-up was the cost.

Specific Advice

Meg saw a psychiatrist regularly, but when asked why she did not see a therapist she indicated that she needed specific advice that would help her to make the changes she felt she needed to make. She wanted more than listening:

It was a waste of my time...I would talk, but once again this seemed to be someone that really didn't have any suggestions for me, and I was like I can open up and talk to someone else without paying this individual to sit here and listen to what I'm having to say.

Motivation

Gwen had a similar experience of feeling that her needs were not met, but in a different way. Her psychiatrist did listen and did give her advice; however Gwen felt she

already knew what she needed to do. She did not want advice but motivation. What would help her do what she already knew she needed to do?

I was paying this psychiatrist thirty dollars a week to go in and tell her my problems, and then listen to her for five minutes tell me what I need to do. I know what I need to do. I don't need to pay you thirty dollars to tell me what I need to do...its just doing it.

Honoring Your Voice

Rachel did not like outpatient therapy because she did not feel listened to:

When you do go to the appointments and you try to tell them how you're feeling and how things are going, then they sit there and disagree with you and say, 'You know, this is how you feel.' They don't know how you feel.

Bonding

Charity also did not choose to go to outpatient therapy. She did see a psychiatrist, but did not choose to continue to see that person because she did not feel the psychiatrist made an effort to bond with her. She describes the visit in feelings terms: "cold", "laugh", "have a good time", "feel comfortable", which indicates she was looking not only for information but a supportive relationship.

When I first left there they assigned me a woman, but being honest, the very first day I went to her I didn't feel a bonding. She was so cold. I'd really gotten spoiled by my previous doctor. He and I, we just talk about everything. We laugh. We just have a good time. He just makes me feel comfortable.

Ben also desired connection, and he saw connection as a form of motivation:

Some people sit there and say, ‘Well, if you do this, this is going to happen, you don’t want to do this.’ That goes in one ear and out the other on people. But if you can actually connect with them, and where they can be like, ‘Yeah, this guy really ain’t as full of it, because he’s explained exactly the way I’m feeling about it, and exactly the things that I feel and think’, you know. Then it helps people get that more of the motivation.

Respect, Not Pity

Ben also had experienced what he felt was being downgraded:

I don’t understand why some people do that, downgrade people and downgrade them. You might as well not even talk to me no more... and I don’t like people giving me a pity trip, feel sorry for me. I don’t like that either.

Create Good Feelings and Self-Esteem

Ben then describes what he does believe people want in therapy, which involves caring, respect and self-esteem, and feeling good:

What they’re looking for is somebody to keep them happy while they’re in there, make them feel better about themselves, show them that there are people who care.

Have Client’s Best Interest At Heart

Meg’s spouse, who was very involved with her therapeutic process, also described why he liked her doctor: “I trust him. I think he has her best interest at heart.”

CHAPTER V

REFLECTIONS ON DISCOURSE

GROUNDING THE DATA IN THE LITERATURE REVIEW

A Theoretical Perspective

Three theoretical perspectives undergirded the development of this research study: a theory of self-efficacy, narrative theory, and theories of depression.

Self-Efficacy Theory

The data from the research clearly indicated that self-efficacy was a powerful concept in depression management, and that many of the key elements and factors promoting self-efficacy were important. Patients who appeared to have higher self-efficacy shared stories of direct mastery experiences (i.e. Gwen buying a home, Julie fighting off depressive feelings) and had significant others giving them positive feedback (Ben's mother who constantly affirmed her son). As they began to feel better physically they also responded emotionally (i.e. Rachel who experienced decreased depressive symptoms when her other physical health problems were dealt with).

Narrative Theory

Narrative theory looks at the dominant stories in people's lives and seeks to create room for alternative healthier stories. Narrative theory describes an internalized community of previous relationships that compose the individual self. It identifies cultural stories and their influence on the lives of clients. The stories that dominated participant's lives were powerful stories. Over the course of the research some participants were able to describe how those stories changed. Ben thought of himself as a drug addict until he changed his story of himself and subsequently changed his

behavior. The influence of cultural stories was exemplified through several clients. Ben had to reject cultural stories of himself and access his mother's alternative stories to promote healing. Rachel had to ignore therapeutic labeling in order to persevere to access the help she needed. In addition to cultural stories, the narrative concept of internalized communities has interesting implications for a treatment of depression that considers the self in relationship to others.

Theories of Depression

Perhaps one reason so many theories of depression exist is because it is such a complex illness. Many of those theories provided frameworks for comprehending the participant's experiences. The automatic thoughts, maladaptive assumptions, and negative schemas were evidenced in many of the participants' stories, such as when Charity spoke of her thinking as keeping her from doing the things she needed to do to get better. Meg illustrated concepts of attribution theory when she spoke of always blaming herself for the circumstances in her life. This also illustrated the concept of self-focused attention. Gloria and Karen both clearly understood the negative effects of rumination described in Nolen-Hoeksema's theory of depression and used thought-stopping and refocusing to terminate it. Rachel corroborated Lewinsohn's behavioral theory of depression as a result of passive, repetitious, unrewarding behavior when she spoke of her life as repetitious, dull, and boring. Julie confirmed the effectiveness of Rehm's theory of self-control emphasizing the use of self-reward to maintain non-depressive behaviors. Nine of the ten participants spoke of dysfunctions in relationships, such as conflict and termination that confirmed the importance of interpersonal theories of depression.

A Research Perspective

In the literature review I reviewed research on rehospitalization, relapse prevention, and self-efficacy and depression. Eight of the ten participants had experienced rehospitalization, although the length of time before rehospitalization varied widely, from one month to several years.

Rehospitalization

Most of the research studies on rehospitalization were quantitative and I did not focus my qualitative research on the same factors that they studied. However, I did observe that Rachel's rehospitalization and her suggestion for quicker aftercare gave credence to Lyon's speculation that readmission reflected quality of community services and Klinkenberg and Calsyn's findings that an initial contact with aftercare services has been consistently associated with lower recidivism rates. Interestingly, the one variable most often associated with rehospitalization, noncompliance with medication, was not a factor in readmission for any of the participants, although problems with medication were. Family relationships were a significant factor for several participants. Gloria, Ben, Karen, Mitchell, Gwen, and Meg all had smaller social networks, which according to multiple sources put them at greater risk of rehospitalization.

Relapse Prevention

All of the participants in the research had been through some degree of relapse prevention training while hospitalized. My research was not designed to compare the effectiveness of relapse prevention treatment with any other form of treatment, which is what the majority of the research focuses on. In my literature review I brought up the question of a focus on relapse prevention to avoid a negative outcome versus a focus on

maintaining and sustaining change to promote “success”. As I interviewed participants I discovered that they balanced a perspective on both. They practiced relapse prevention in order to avoid a relapse into severe depression and rehospitalization and they focused on creating and sustaining changes that would move them forward toward positive goals in their lives.

Family functioning was again an important factor in understanding relapse prevention. The emphasis that participants expressed on the importance of voice underscored Friedmann et al’s (1997) observations about the association of communication in family dysfunction and depression. On a positive note, Meg’s husband, who was actively involved in her treatment, confirmed Johnson’s research on family functioning that stressed the importance of involving families, who often recognize the early warning signs of decompensation.

Depression and Self-Efficacy

Most of the participants in the research had chronic depression that they had experienced for years. Relapse prevention was not about preventing the return of a disease because it never fully went away. Relapse prevention was about keeping it from deteriorating. Several studies on depression associated relapse with dysfunctional attitudes or negativistic beliefs. It was my observation that during the times participants were not doing as well, they did experience more negative beliefs about themselves and their world. In my research it was not possible to obtain much information on formal treatment methods, because very few participants were in formal treatment; however, I did observe that several of the participants who were actively managing their depressive symptoms used traditional cognitive behavioral techniques to do so. As in the field of

relapse prevention research, some researchers specializing in understanding depression have begun to question the difference between being asymptomatic and having a sense of well-being (Hall and Nelson, 1996). The two factors identified contributing to well-being were a sense of control and the availability of support. Both of these concepts confirm the importance of self-efficacy and connection that the participants shared with me. Although Davidson's work focused on patients with schizophrenia, he found highly significant change in rehospitalization rates when he addressed the issues of social isolation and lack of self-efficacy. The emphasis of my research participants on the importance of self-efficacy and connection confirms the importance of his findings. Bandura's work on depression linked low self-efficacy beliefs to depression. Consistently throughout the research depressed participants verbalized their feelings of helplessness and hopelessness, which are aspects of self-efficacy. They also had a low sense of social efficacy (Holahan and Holahan, 1987) through loss of connections. Many studies emphasized the influence of stressful life events in promoting depression. Several of the participants in my research had extremely stressful life events.

COMMON THEMES THROUGHOUT THE DISCOURSE

In reviewing the discourse, several themes emerged consistently from the data throughout all of the discussion questions: connection, self, voice, self-efficacy, and "knowing". Most of the themes were balanced with opposite poles of the same concept, and both poles were important in the discourse.

Connection

The need for connection is a basic human need, and the loss of connection occurs

in many ways. Some of the ways identified in the research are aloneness, death, divorce, separation, and attachment injuries. One of the most commonly expressed descriptions of the loss of connection in the research was a sense of aloneness. Gloria associated the realization of being alone at the season of Christmas with the start of her major depressive episode and the need for hospitalization: “that’s when I ended up in the Rehab, right over Christmas; because I couldn’t stop crying, because here I am sitting all alone.”

Ben in his description of suicidality raised several of the research themes: connection, voice, and self-efficacy:

The reason I’ve always been suicidal is because I felt like I was so alone there was nothing else I could do, you know, and there’s no hope for me because I’m so alone, and I don’t have nobody that I feel like could truly love me and all this, and I don’t have nobody to sit down, no friends or nothing to talk to and stuff.

He associated being alone with a sense of powerlessness and hopelessness, and not being able to use his voice. Ben acknowledged his greatest fear to be a loss of connection with his mother: “The main thing I fear with my mother and stuff is I don’t ever want her, which I know she wouldn’t ever turn her back on me.”

Meg described her isolation in terms of her feelings when she described her depression:

It’s very frustrating to feel like everything is closing in, but yet you know you’re the only one that is feeling that way... You just wonder why am I feeling this way if the other person around me is not feeling that way.

Many of the participants went through a separation, divorce, or death of a loved one, which can also be considered a loss of connection. Most of the participants had several losses of connection.

Although death often is experienced as a loss of connection, the grieving process may bring some resolution of that loss. Karen was able to have a sense of reconnection with her parents that helped her: “I’ve learned that although they’re gone, they’re really not gone, because there’s a little bit of both of them in me.” In talking about this learning experience, Karen was touching on another theme to be discussed later: knowing.

Although they were still living, Mitchell experienced the loss of his children through a loss of connection associated with not visiting or talking: “I mean I lost four...kids. He defined knowing that they care in terms of visiting or talking: “They’d come and visit a little more, and just talk.” Basically he saw connection as a result of voice and presence, a result of the behavior of visiting.

Not all losses were of relationships; however, some of them directly impacted participant’s ability to connect with themselves or others. Both Ben and Mitchell spoke of losing their driver’s license and their inability to work as having a direct impact on their illnesses. Both lived isolated lives. Ben was very connected with his mother and his friend Fred, but had disconnected himself from others. Mitchell felt disconnected from everyone except his mother, who was one of his major stated reasons for not committing suicide.

Many of the participants told stories indicating they had experienced an attachment injury. Gwen described several attachment injuries throughout her life in

many of her relationships: “In the beginning with my first boyfriend I got beat, had my baby beat out of me, and every man after that just was beneath me.” More recently, she described a severance in her relationship with her father after he remarried. “As far as we’re concerned he don’t have a family anymore. He don’t come around. He don’t call.” In this description of loss of connection she identifies two factors contributing to a sense of connection: presence and voice. Presence is expressed in the behavior of coming. The injury that appeared to be the most difficult, however, was the sense of abandonment she felt from her siblings over her mother. In her conversation about the injury she described the particular incident resulting in injury and loss of connection and then identified her response: the silencing of her voice and a sense of wounded self. A loss of connection appeared to result in the silencing of her voice and a wounded self (increased depression). It is interesting to note that in this case the injury that resulted in a loss of connection was a refusal to help. Behavior as well as voice contributed to a sense of connection:

I said, “You’re supposed to help me.” “Well, I don’t have time. I have a family.” I said, “But you also have a mother.” “Well, I just don’t have time.”

And to keep from arguing with them I just hung up the phone and never asked for help again. They’re my family. I love my family, but this pitch I got, I hate it. I don’t think I’ll ever recover from it.

Although participants usually spoke of loss of connection, they yearned for connection. One way they expressed this was in their description of what they appreciated or wanted at the Rehab and in outpatient therapy. Karen appreciated the inpatient staff because they frequently checked on her and because they were “genuine”

in their caring. She described leaving the Rehab in vivid terms that indicated a loss of that connection: “It’s like turning your child loose. ‘Okay, don’t go out in the road’, and then you open the door and you turn your back.”

Ben appreciated the staff because “they made me feel so much better about myself.” His words indicate the importance of positive feelings in connection. He described the staff as laughing and joking with him. Apparently this interaction of connection helped to produce increased self-esteem, which is often associated with decreased depression. Ben not only described connection in therapy, he defined it:

But if you can actually connect with them, and where they can be like,
‘Yeah, this guy really ain’t as full of it, because he’s explained exactly the way
I’m feeling about it, and exactly the things that I feel and think.’

For him connection is the knowledge that another person knows what is inside him (i.e. his perceived self). Ben also described reasons that he intentionally cut off connection with his therapist: “I don’t understand why some people do that, downgrade people...You might as well not even talk to me no more”. When he felt injured (downgraded) by another, he silenced the voice of the other by tuning him out. Although he did not say so in this part of the conversation, I wonder if he silenced his own voice as well. He admitted doing that in another part of the discourse for other reasons.

Meg’s husband described a sense of loss of connection associated with no one calling him and with not hearing the communication of important information. “To be secure ...I wanted the attending to ...call me ... I just felt like sometimes, ‘Gosh, evidently we’re just out here on our own.’” He did not describe becoming depressed himself because of a loss of connection, but he did express isolation.

Indirectly, Meg's husband summed up the character of connection when he described her current psychiatrist: "I trust him. I think he has her best interest at heart." In connection there is a trust that the one we are connected to will not harm us and in fact seeks our well-being.

In addition to connection with their therapists, participants sought connection with others as a form of healing. Karen intentionally sought others out when she left the Rehab because she knew that she needed to be with other people: "I thought the worst thing for me right now is to be alone, so I started reaching out to people. I don't think there is a day that went by that I was alone."

Julie talked to her friends about the things that fed into her depression, which became a healing factor for her: "When I have problems I got best friends I can call and talk to. They're my sounding board. They're my help. It's okay."

Self

Many of the participants described their depression in terms of a sense of either wounding of self or loss of self. When Julie referred to the depressive state she was in previously, she recognized that if she did not take care of her own needs, "I'm going to be right back where I was two years ago, with no identity, no wants or anything." She understood that taking care of her own needs might come at a cost of offending others: "I can't please everybody."

Gloria gave a powerful description of depression as a sinkhole and her powerlessness as she lost herself to depression: "There's a big sinkhole and I say, 'No, I don't want to go in that again. I don't want to go in there.' And then I start going toward the sinkhole, and I start sinking into that big

sinkhole, and it just sucks me up, and sucks up the car and the whole thing, and I am gone.

One of the most poignant descriptions of loss of self came from Ben who described an intentional severing of connection with himself in order to prepare for prison: “I’ve already prepared myself to go out of my heart. I’m already starting the stages of kindly separating from people I love and to not be so devastating”. It is no small coincidence that he equated going out of his own heart with loss of connection from others.

Ben’s mother also used very graphic terms to describe the loss of self that Ben had already experienced because of the multiple deaths in his family. She too was equating loss of connection with loss of self:

It grates his heart. It’s real hard, and what I’ve always tried to tell Ben, ‘You got to find a place in your heart, you know, and go visit it, but you can’t dwell on it, cause it will eat you alive,’ and that’s what he was letting it do was eat him alive.

Although participants described depression as a loss of self they also described healing as a finding of self. In describing her progress, Karen related her healing to finding herself and to connection with a loved one. I question how related those two factors of finding self and becoming connected are.

I don’t really have long periods of depression anymore. I feel like I know what I want, I know where I’m going, I have you know, this to look forward to, and you know, I know that I’m with somebody that I love.

Ben used his understanding of whom he was to help him give up his drug use:
“Ben, this ain’t you.”

Most of the participants who referred to a loss of self or used metaphors indicating a wounding of self, expressed low self-esteem. There were two clear exceptions. Gloria claimed to have high self-esteem and yet acknowledged the loss of self associated with her depression:

I’ve had counselors tell me ‘create a new self’. No, I’m not going to create a new one, cause the old one is plenty good enough for me. (Laughs) I mean I have good self-esteem, I really do. And I am my own best friend.

Gwen also worked actively on her self-esteem and her self-description reflected it: “I saw what I could do, what I could be, what a beautiful person I am, and I don’t want to ever lose that again.” There is not enough information from the interviews to determine the relation of self esteem and loss of self. In addition, the factor of the interviews occurring over time needs to be considered. Depression is not a static illness and there are degrees of depression that change over time. Most likely the days Gloria and Gwen talked about their self-esteem were days that they were feeling much better and their descriptions of depression referred to a previous time.

Voice

One of the themes that occurred frequently was the theme of voice. Using their voice was a way for participants to connect with others or with themselves, and that connection was a form of healing. Participants often felt others silenced their voice or they acknowledged they silenced it. They associated the silencing of their voice with depression. In contrast they associated the expression of their voice with healing.

When Ben went to his first therapy session, he quit talking in response to the therapist's words to him:

She looked at me and I remember her exact words. She said, 'You're too messed up for us to deal with'... And when she said that I got up, I just got up, turned around, didn't say another word.

He described the meaning of that experience to his mother when he called her and said, "I'm not worth nothing.... I'm not worth helping. She done told me." In that experience, Ben lost connection with someone scheduled to help him, lost his voice, and in so doing, redefined himself as worthless. Essentially, he lost himself.

The silencing of self also occurred in families. Gloria described an experience that occurred years earlier with her daughter, but she associated it with her present sense of being disconnected from her daughter: "I was trying to talk to my daughter one time about my life as a nurse... She said, 'I don't want to hear about that... So I feel now she doesn't know me'. That sense of aloneness was one of the primary reasons she identified for her depression.

Rachel silenced her own voice out of her experience of being silenced by her husband:

Sometimes I get aggravated like if I try to talk to him or something. I mean I don't even know what and how I feel, and he sits there and tries to tell me what and how I feel. Even if I told him, he probably wouldn't listen, because I can try to tell him something, and I'll be in the middle of a sentence or whatever, and he just starts talking to me about something totally different.

Ben also silenced his own voice in what he believed was a way to protect others, however he remained depressed: “I try not to let other people know I’m down because I don’t want to drag nobody else down with me.

In contrast to the times of silencing, many participants described actively using their voice to relate to themselves as well as to others. They sought to encourage themselves, challenge themselves, speak their feelings, and find commonality, all of which often helped them to get better.

Charity used her voice to motivate herself, reminding herself what would happen if she didn’t follow through: “You got to go because if you don’t go you will never go.”

Gloria and Karen both managed their depressive symptoms with thought stopping, a challenging voice to self. Julia encouraged herself with her self-talk: “It’ll be all right. It’ll be okay.”

Julie saw her voice as her prevention for the depressive feelings, which she described as taking over her self-control: “if I feel it seeping in, I talk to somebody, cause if I don’t talk, then it’s going to jellyroll me. It’s going to wrap me up and...” Essentially, this is a description of the importance of voice in preventing loss of self.

Ben’s mother also used her voice to claim who she now was when she told Ben how she really felt about his upcoming imprisonment:

I don’t have to be strong and fight ya’ll’s fights anymore.’ I said, ‘I can feel the emotions I need to feel now’, and I said, ‘That hurts.’

In her statement, she both connected with herself and disconnected with the role of rescuer of Ben, essentially forcing him to fight his own battles. This illustrates the importance of a sense of connection even when it is not always positive. A person can be

encouraged to use their own strengths and change through what appears to be a severing of connection or dependence, however this is still a form of connection.

Karen used writing as a way of expressing her voice in a conflictual situation, which she connected with feeling better: “I wrote her a 14 page letter and I told her just what I thought and how I felt... I have felt good ever since.”

Both Meg and Gwen used their voice to find a sense of commonality with others, which is a form of connection. Meg stated:

Just talking to others sometimes helps. Talk to other people and find out that they worry about little things too. You know my friends do so. I’m not the only one.

Meg also finds support from her spouse. He views her ability to talk with him as a healing mechanism: “You know I usually hear about it, and just the sounding it out and talking about it probably helps her to deal with those issues.”

Self-Efficacy

Self-efficacy is a factor that has been associated with depression and relapse prevention in the professional literature for several years. Although participants did not know nor use the term “self-efficacy” they spoke in words that implied self-efficacy. In general, when they talked about their depression, they spoke about their lack of self-efficacy, and when they talked about their progress, they used concepts associated with self-efficacy.

Descriptions of Low Self-Efficacy

Words describing low self-efficacy and that are often associated with depression include “helpless”, “overwhelmed”, “powerless”, and “no motivation.” Mitchell

described his need for hospitalization because he felt “helpless” after losing his driver’s license.

Meg described a situation in which her feelings were in charge and she felt powerless to change them. She used the term “overwhelmed”.

It seems like it’s nothing that I’m able to do at the time to change the way I feel, unfortunately...sometimes you just feel doomed... I usually feel overwhelmed at the time that I’m experiencing those feelings.

Gwen described depression ruling her appetite, so that she lost control of her eating:

I get depressed sometimes and that’s when I eat and that’s when my diabetes gets out of control. I eat as long as I’m awake, so I have to make myself go to sleep so I won’t eat. Gwen identified her work as a stressor for eating.

Descriptions of High Self-Efficacy

One of the factors promoting self-efficacy is the ability to accomplish goals. Karen eloquently illustrated this in her description of her recovery.

I learned in the Rehab to make goals for every day. I did and I felt like I had accomplished something and it helped me to do bigger things.

Mastery experiences also increase self-efficacy. When Gwen succeeded in buying a house, she stated, ” I knew Gwen you can do anything you want to do, anything, even stop drinking”. Gwen built on that sense of mastery to help her achieve successes at work, where she challenged insubordination.

Self-efficacy concepts are related to concepts of power and control. When Ben experienced success in keeping himself drug-free, he understood power:

I always let people tell me that you can't control yourself sometimes, which is wrong. You can always control yourself. You can always tell. You always got a choice.

Several participants expressed that same sense of power when they spoke of depression management. Rachel stated, "Learn how to take a little control over your emotions, instead of letting your emotions and everything control you". Julie and Charity both described a perseverance of pushing through problems to prevent relapse. Charity stated: "I'm just gonna keep pushing. I'm not gonna sit this out. Just go anyway."

Part of self-efficacy is the ability to motivate oneself. Julie used a reward system to help herself stay motivated.

Although action in and of itself is not a facet of self-efficacy, actions that promote mastery or goals directly boost self-efficacy. Many of the participants described the importance of taking action as a way of helping them ward off depressive feelings. For example, Karen stayed busy by reaching out to other people. Rachel understood that work kept her from succumbing to depressive behaviors. Gloria wanted to stay busy, but because of her physical problems redefined that busyness as using her mind to stay busy.

Knowing

Knowing is a concept that was not thoroughly explored in the interviews, but which I became aware of as I analyzed them, and I mention it because I believe it is significant and deserves further consideration in later research. I define knowing as the acceptance and internalization of information so that it becomes no longer knowledge but rather a part of who you are. The process of knowing transforms intellectual ideas into lived experience. When participants spoke of having "learned" or "knowing", they

owned that knowledge, and it was as if they knew it with their whole being. Karen uses the word “realized” to describe her process of learning about self-acceptance and forgiveness, which she was living out in her daily life in her relationship with her boyfriend:

I realized I was just as human and accepting that was great. I had to learn to forgive him and to forgive myself. Forgiveness is real hard, but I can forgive.

Gwen’s story about her house also illustrates this concept of learning: “So, with that I knew Gwen you can do anything you want to do.” Gwen had learned through her experience, had interpreted that experience, and now lived out the belief she developed because of that experience.

The participants took what they learned in their lives and used it to help themselves. When they talked about what they had learned, they shared it as if they were sharing part of themselves, and they were often excited and enthusiastic about it.

Although there is much that I do not understand about the process that enables that kind of learning, I have experienced it myself, and recognize that it is in that kind of learning that people are changed. That is the goal of therapy. How do we help people experience that kind of learning?

Relational Theory of Depression Management

Figure 1.

Self Connection

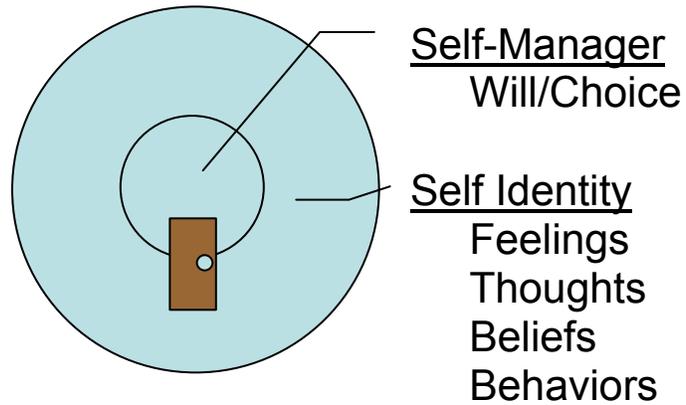


Figure 2.

Other Connection

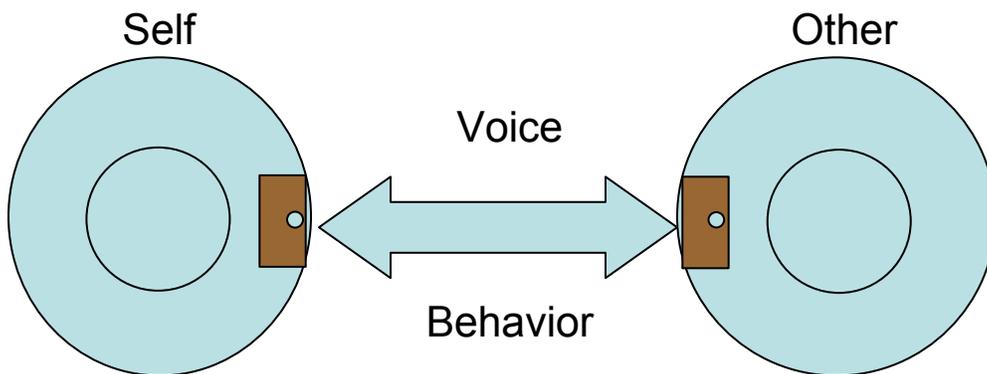
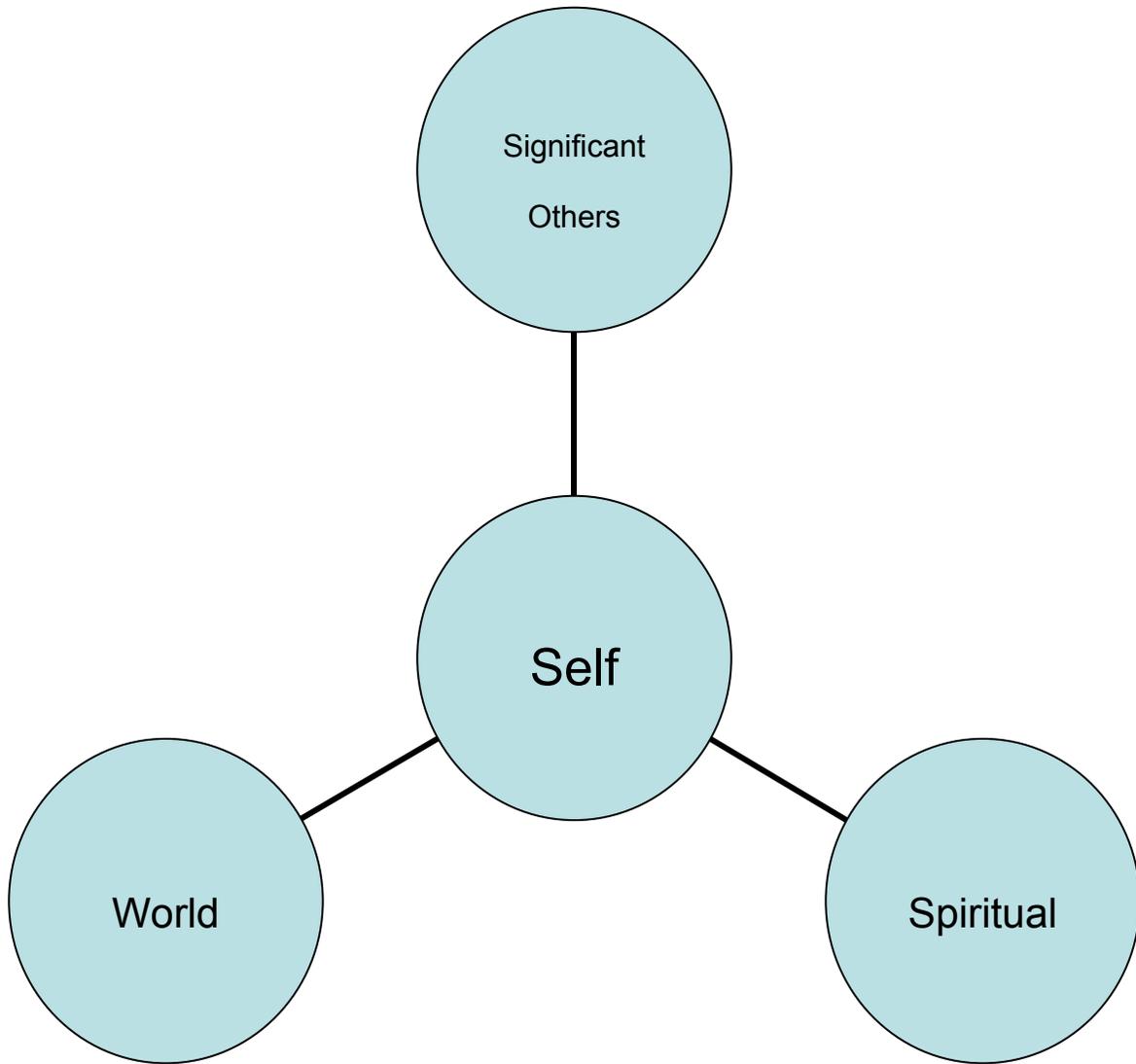


Figure 3.

Systemic Connections



THE GENERATION OF NEW THEORY

A Relational Theory of Depression Management

Researcher's Perspective

Throughout my conversations with the participants as I listened to their stories I heard over and over again the common themes of connection, self, voice, self-efficacy, and knowing. As participants shared their stories of their depression they frequently shared about a loss of connection. Types of loss of connection included loss of connection with significant others, with self, with systems, and spiritually.

In terms of their depression the loss they so vividly described was the loss of connection with self. There were many other losses that they grieved, but what appeared to happen was that when they suffered a loss of connection with self or another, they experienced it as a loss or wound to self, and it sometimes became a loss of self. I began to think of depression as “The Wounded Self” or “The Lost Self”.

The three factors that seemed to feed into that loss of self or wounded self were self-efficacy, voice and action. The participant's descriptions of themselves as helpless, powerless, and overwhelmed without motivation and with no goals in life reflected a loss of self-efficacy. It was not that they had not tried to change their situations. Rather, they saw no way to change their situations. They no longer believed that they could. This loss of self-efficacy became part of a greater picture of a loss of connection with self. I began to think of the self as composed of a self-manager, who operates one's will and choice, and the self-identity that is composed of our feelings, thoughts, behaviors and beliefs. (See Figure 1.) There is an inner connector door which controls the amount of connection experienced by how far open or shut it is.

In loss of connection with self, essentially the connector door is shut between one's will and choice and one's self-identity. Loss of self can occur anywhere in this system. One route to this connector door being shut may be a loss of self-efficacy because of one's own failed efforts, for example, when Meg described the helplessness that she experienced when her feelings were so powerful that she could not refute them; or when Gwen talked about knowing what she needed to do but not being able to make herself do it ; or it may be because a person is in a relationship where someone else's will takes precedence, for example when Julie voiced her fear that if she tried to please others by constantly giving her time to her four children rather than allowing time for herself, she would lose her identity. Although this was not spoken of directly in the discourse, another example that comes to my mind is in situations of unequal power structures, such as abuse, where the person in power overrides the will of the person not in power, thereby undermining their sense of self-efficacy. Charity indirectly described these circumstances when she spoke of the recurrence of her depression, however during the interviews she never spoke of a loss of self, only of depression.

It was just after I married the man that I married, that it came back again, cause I was scared of him. I didn't know he drank and raged and stuff. And I didn't weigh but, I guess I weighed about 98 pounds; and he's a great big man.

It is interesting to note that when I re-contacted Charity and reviewed my theory with her she agreed with the concept of depression as a wounding or loss of self.

Other routes to the door of connection being shut or open appear to be behavior and voice. Looking at the concept of self-connection, Julie used the concept of behavior to stay connected with her self-identity as a healthy person. When she identified

behaviors that she felt were not part of who she was, she saw them as part of her depression (behaviors that she would not normally do if she were not depressed), and whenever she noticed that she challenged those behaviors. I have no direct examples of negative self behaviors stopping connection, however it was interesting to me that Julie described her behaviors of constantly pleasing others as a loss of self-identity, and Ben, who had engaged in years of drugs use, voiced a desire to get to know who he was after he stopped using.

In loss of connection with self, I have no examples from the discourse that come to my mind that illustrate the absence of voice, however Mitchell used a negative voice when he referred to himself as a “complete idiot”. A negative voice is another form of self-wounding, which can create a loss of connection.

There are many examples of participant use of voice in a positive way that illustrate connection and promote healing. For the use of voice to promote connection and healing with self, see the section on self-talk. Essentially, the examples involve use of voice for encouragement, challenging self, re-labeling oneself, and venting.

In loss of connection with others, there is also a connector door between self and the other that the self regulates. (See Figure 2.) The pathways of connection remain voice and behavior.

Participants recognized the importance of behavior as a form of connection with others, with the type of behavior usually being helpful behavior or simply visiting or presence. What type of connection participants considered important appeared to be related to their need. For example, Mitchell, who was unable to get around by himself

other than in an electric wheelchair, valued concrete helping behaviors. Karen, who had many strong feelings pent up inside of her, valued the use of voice.

In seeking connection with others, the participants most frequently verbalized the importance of voice as being the major connector route. In loss of connection with other, there are many examples of voice resulting in a loss of connection, such as when Ben's therapist refused to see him, thereby severing connection. There are also many examples of voice resulting in connection. One example is Julie accessing her friends as her main method of support.

It is important to note that connection is a two way connection, so the severance of connection may be from self or other and the negative use of behavior or voice, the denial of voice, or the silencing of voice may also be from self or other. Likewise the building of connection may also begin with self or other.

What determines if a severed connection results in a wounding or loss of self? There are a few clues from the discourse. It appears to be how much one values that connection. One example is Gwen's comments about losing herself. Gwen valued herself immensely, and she stated that if she relapsed she knew that she would lose everything, including herself. If that happened, she knew that she wouldn't want to live anymore. Likewise, Ben spoke of his unconditional love for his mother saying she "might as well be my heart". The only thing he feared was her abandonment.

What enables someone to open or shut the door of connection depending on the healthiness of the connections? This is an issue that was not really dealt with in the discourse, but would be important for further exploration in research. If loss of connection with self or other can occur, can reconnection occur? There are times when

reconnection can not occur in the same way that it was before, such as in the lives of participants who experienced a death or divorce; but there are other times when reconnection is possible and may be an avenue of healing, such as in Karen's reconciliation with her partner and Julie's active self-care in order to retain her identity.

If reconnection can occur, how does it occur? The discourse does provide a few clues. Karen's discourse on self-acceptance and forgiveness of herself and her partner indicate that she intentionally opened the door to reconnection by her willingness to forgive. Julie's, Ben's, and Gwen's discourses on the importance of wanting to manage their respective illnesses indicate a strong sense of self-management with increasing self-efficacy contributing to their reconnection with themselves.

I would like at this point, however, to raise a therapeutic issue. In my presentation of the initial results of my research, one of my colleagues observed that it is easy for the mental health field to convey the message "I should be able to fix myself." If that is the message that we glean from concepts of relapse prevention, then we are trivializing the complexity of depression, a complex illness with many factors feeding into both its course and its management, including biological factors, and we are in danger of "blaming the victim". There are wounds that may never be healed. Most assuredly there will be scars.

The whole point of this theoretical perspective is that loss of valued connection fosters illness and healthy connection fosters healing. From a theoretical perspective, it is in connection that healing occurs. One aspect of this model that helps provide healing options is that we have more than one connection. (See Figure 3.) We may have a loss of connection in one area of our life and very healthy connections in other areas. Meg's

case could possibly be considered as a negative case example of the theory. Meg's depression began with mourning the death of her parents and the loss of connection with her extended family, but she had a very strong connection with a very healthy nuclear family (husband and daughter). She also intentionally sought to reach out to close friends who also served as support connections. In addition Meg had a spirituality that she relied on as another source of connection. Did all these connections free Meg from depression or keep her from becoming depressed? No, so healthy connections did not necessarily produce healing (i.e. disappearance of the disease), but Meg identified these connections as pathways of healing in her life. She understood that her depression was chronic. She wanted to be completely free from the symptoms, but in the meantime she focused on ways to manage them and the strong connection she had with her husband served to promote that management.

If connection is a pathway to healing, how much connection is necessary? That question can not be answered from the data. Yet it points to the issue of the intersection of theory and clinical practice. Using this model as a theoretical base for clinical practice, how can it be applied to practice? Certainly one way is to begin to look for the influence of strong connections and severed connections in people's lives, the connections with themselves, others, and the world; and to identify how the pathways that created those connections are working. Where there are severed connections, one might explore whether reconnection is a possibility and if so, how. If it is not a possibility, one might look at alternative connections to see what can be strengthened or added and through what specific pathways connections can be built.

A Collegial Perspective

I have discussed the grounding of the data in the theoretical perspective from the literature review, so at this point I will discuss the current theoretical frameworks that seem most relevant to a relational theory of depression management. As my theory began developing, it became important to me to understand what support there was in the field of marriage and family therapy for such a theory.

In her article on the use of marital therapy to alleviate depression and marital distress, W. Kung employed a systemic perspective of depression viewing an individual as a biopsychosocial being and recognizing that in order to treat depression, one must consider not only the interpersonal aspects of depression but also the biological and intrapsychic factors. (Kung, 2000) In his article reviewing the factors that contribute to marital distress and co-occurring depression and effective marital therapy treatments, D. E. Mead emphasized the importance of educating people that depression is a chronic, illness with biological components and depressive behaviors in response. He reminded the reader that: “Depression cannot be overcome by the exercise of willpower.” (Mead, 2002)

Although my research focused on understanding depression and its management from the perspective of the individual diagnosed with depression and that of a significant other and therefore does tend to examine what the individual believes she or he can do to best manage the illness and how others contribute; as previously stated, I acknowledge, agree with, and wholeheartedly support the idea that depression is a complex illness and its multiple factors must be considered in treatment. For example, it is very difficult to sort out the influence of medication and therapy in interacting with improved

circumstances to determine what creates healing. At issue also is how one defines healing. Since depression is a chronic illness, is the goal of healing the alleviation or the absence of symptoms versus the disappearance of the disease? On the whole for the participants in my research, depression management meant accepting the illness as chronic, working to alleviate or reduce symptoms to a minimal level, and continuing to monitor the disease indefinitely.

Because my theory was systemic in nature, I continued to look for systemic theories to enlighten my own understanding of my thinking. Susan Johnson's writings on attachment injuries emphasized attachment theory, which confirmed the direction of my thinking. Attachment theory, originally formulated by John Bowlby, is an interactional theory in which self and system interact to define and determine each other. (Johnson, 1996) It identifies the seeking and maintaining of contact as a primary motivator in human beings. Bonds formed between human beings, consisting of behavioral, cognitive, and emotional elements, are constructed through emotional accessibility and responsiveness. These emotional bonds, formulated through contact, form a buffer against stress. When the bonds are threatened, individuals seek to maintain attachment through various attachment behaviors. If these behaviors are not successful, a process of protest, clinging, despair, leading to detachment is initiated. Adults have four attachment styles that are connected with their internal workings models of themselves as lovable versus unlovable and others as responsive and accessible versus unresponsive and inaccessible. (Johnson, et al., 2001). These styles are secure, preoccupied, dismissive avoidant and fearful avoidant. An attachment injury occurs when there has been a specific incident that represents an abandonment or violation of trust in a relationship.

The seriousness of the injury depends on how the injured party interprets the injury and how the injuring party responds when confronted. Unresolved attachment injuries may challenge self-concepts. Johnson believes attachment is an important factor in creating resilience and the resolution of attachment injuries is the mechanism to restore attachment. She outlines eight steps to resolution. Those steps basically involve a confrontation of the injury, seeking understanding, forgiveness, and an opportunity to express attachment through risk and response sequences.

It was obvious to me that there are many correlations between my thinking and attachment theory. The idea that self and system interact to define and determine each other is implicit in my theory. The concepts of connection and attachment bonds are very similar. The formation of bonds through emotional accessibility and responsiveness is similar to the concept of the formation of connection through the pathways of voice, behavior and self-efficacy. It is the use of voice that creates emotional accessibility and responsiveness is a behavior. The concept that bonds form a buffer against stress supports the idea that connection is a healing process for depression, which is certainly a stress to the individual experiencing it.

Attachment behaviors are described with words that also describe depression (i.e. despair, detachment are both components of symptoms of depression.) Although an attachment injury could certainly be seen as a severance of connection, Johnson's definition of attachment injury is too narrow to substitute for the many ways connection may be severed.

Interestingly, Johnson's concepts of resolution of attachment were illustrated in Karen's description of her confrontation with her boyfriend and his willingness to listen,

which changed the pattern of their communication and opened the door to reconciliation. That discourse also supported my belief in the importance of the process of forgiveness in healing.

My relational theory of depression differs from attachment theory in that it has a broader definition of the concept of self, and the concept of connection can be more generalized than the concept of attachment normally is. For example the idea of self in relationship to self as part of a connectional system that promotes healing is important. In addition a very important connection that has been implied in the research is that of self to the larger system. In the case of depression, multiple systems interacting with an individual experiencing depression include the private and public mental health treatment systems, the pharmaceutical companies that manufacture and market medication, the government that funds research on depression, the insurance industry, etc. As demonstrated in the research these connections are important to an individual and influence treatment and prognosis.

A second theory that I want to mention is the Silencing the Self Theory by D. C. Jack (1999). It too is a relational theory built on the framework of attachment theory. In a longitudinal study Jack interviewed twelve women who were depressed and consequently applied her theory to women. As a relational feminist, she stresses that women's sense of self is organized around connection, mutuality, and relationships; and self-esteem is tied to the quality of attachments. She believes that women experience a loss of self or self silencing as a result of efforts to alter the self to meet the cultural expectations and/or needs of the men they love. Treatment involves not only exploring a

client's image of relatedness but also the cultural context that shapes and forms these images.

I see her theory as an important contribution to understanding depression and agree with the emphasis on the concept of voice, but I believe that the concept needs to be expanded, since others may also silence voice as well as self. I also believe that the multiple factors contributing to depression require a broader theory in which to explain it.

In addition to the attachment theories, I found similarities between my conception of the self and Richard Schwartz's model of internal family systems (Dattilio, 1998). Schwartz conceives of the mind as composed of an inner family with various parts: the "managers" assume protective, managerial roles, the "exiles" carry the emotions, memories, and sensations of negative experiences, and the "firefighters" distract the self to enable dissociation from the negative feelings of the exile. In addition, there is a core "Self" that exhibits the leadership qualities of perspective, confidence, compassion and tolerance. The goal of therapy is to enable everyone's core "Self" to rule and relate to other core Selves.

THE INFLUENCE OF THE RESEARCH

Influence on the Researcher

Although I have always held respect of the client to be the foundation of the privilege of doing therapy and considered therapy to be co-constructed, conceiving of the client as a partner in that process; I feel somewhat as Job did when he experienced God's presence and responded, "Surely I spoke of things I did not understand, things too wonderful for me to know. My ears had heard of you, but now my eyes have seen you." I believe and hope that I am forever changed by my research.

There are degrees of knowing. Because of the courage of the participants to share their stories with me, I have a better understanding of the process of depression, how it affects people's lives, how they struggle with it over time, and how they interact with their world to manage it. I also have a better appreciation of the power of relationships to impact depression, both negatively and positively. I am left with a deeper respect for the courage of those who struggle with illness in any form. It is my sincere desire that any work which I do in the future will provide an opportunity for participants to connect with me, with others, and with the larger system in a healing process through the freedom to share their voice and healing behaviors.

Influence on the Participants

Because the data collection of the research occurred over time, I was able to notice changes that occurred over time in the participant's lives, including progress or lack of progress in recovery from depressive symptoms. As a systems therapist and researcher, I firmly believe that the research process itself impacted the lives of the participants, however, I neglected in the interviews to ask them how they thought it did. Therefore any observation at this point is speculation based on external evidences of change. In every case except one, Mitchell, the participants improved over the formal time of the research. (In my most recent contact with Mitchell, he also had improved.)

During the research process the participants had an opportunity to use their voice to tell their painful stories of depression. They also had an opportunity to reflect on self-efficacy issues in terms of what they believe had helped them get better. In other words, in the interviews they were accessing the very things that they mentioned in the research as being helpful for recovery. It is impossible to determine how much the opportunity in

those sessions to use their voice, to focus on empowerment methods, and to form a sense of connection with another human being influenced their ability to better access healing throughout the process of the interviews. The research became part of their connectional system, and therefore I believe that it did make a difference. A small indicator to me of that fact was their continued willingness to have contact even months after the final interviews. A few other factors which I am sure influenced the outcome were medication, outpatient therapy (for the very few who received it), positive changes in environmental circumstances, and ongoing healing connectional relationships with significant others.

RECOMMENDATIONS FOR THE FUTURE

Recommendations for Further Research

Answers to research questions raise new questions. This study was no exception. I began this study with a firm belief in the value of qualitative research to enable researchers to understand client's needs and develop meaningful treatment methods based on clients' perceptions. The identification of themes of connection, self, voice, self-efficacy, and knowing and the development of a relational theory of depression add to the existing schools of knowledge and are part of the process of developing a comprehensive approach to treatment of depression. Further questions that these themes and theory raise: What enables clients to open and close the doors of connection? What types of connection are most effective in decreasing depression? How much connection is needed? (There are degrees of intimacy.) How many connections are helpful? What specific types of pathways (ways of using our voice and types of behaviors) best promote connection? How do we promote connection when the primary characteristic of

depressed persons is isolation? Since the present research points to the use of voice and behaviors that reach out, what facilitates the use of voice in relationships?

The emphasis of marital and family therapy research has been on the interactional nature of relationships, however in depression one primary relationship is that of the self to the self. How can we as a field more fully conceive of the self as an interactional relationship and incorporate the study of self-connection within the larger context of other-connection? What do we already know about systems and what are we willing to incorporate from other schools of knowledge that will aide in this process? We need a more defined understanding of the self and how it relates systemically. How can the concept of knowing be translated into research on how clients learn and how they use that learning to create changes in their lives? D. Sprenkle (2003) in his article on effectiveness research in marriage and family therapy identified this issue of learning and client change processes as a major research emphasis for the field.

Lastly, several researchers have identified family resiliency as a concept for research, with current emphasis being on differentiating the family as a protective factor for individuals, the family as a risk factor for individuals, and the identification of family resilience as a concept in itself to be studied in terms of its effect on the individual. (Hawley & DeHaan, 1996; DeHaan, Hawley, & Deal, 2002; Patterson, 2002; and Walsh, 1996). In my research all three conceptualizations of resilience were illustrated in the lives of the participants and all three impacted their well-being. Walsh recommended studying affirming belief systems in families using qualitative methods. DeHaan, Hawley, and Deal recommended investigating all three of Walsh's categories of family resilience: belief systems, organized patterns such as a sense of connectedness and

communication processes, such as use of voice. The participants in my research identified all those concepts as important pathways for healing. Expanding the research to better understand the influence of family resilience on depression and how connection promotes resilience, presumably alleviating depression, would provide much needed information for treatment.

Recommendations for Treatment

I outlined earlier under The Generation of New Theory how my practice of therapy would be changed specifically related to the theory. At this point I make general recommendations for treatment.

In an article on self issues for family therapy educators, F. Piercy (Kiser & Piercy, 2001) states that “we look for who we are in the eyes of others and grow to the size they see us.” In the same article D. Sprenkle shares his personal story of major depression and the result of being willing to use his voice to share that story with colleagues and students: “I was awed by the caring and the depth of the connections that I experienced...This sense of community was the real balm my spirit needed.”

Based on the recommendations of the participants, I believe it is our responsibility as therapists to look beyond the external circumstances that our clients present to us and together with them to help develop a vision of themselves and their relationships in the present and the future that enables them to move forward with the courage and confidence born of the acceptance and caring they have found for themselves in therapy. That acceptance and caring is the foundation for a sense of connection that we offer clients when we invite clients to use their voices to share themselves and to access new behaviors.

The recommendations of the participants haunt me in their simplicity as I wonder how it is that they have not experienced these things. In essence, they ask us to go back to the basics:

Listen, Respect, Encourage, Care

Out of these elements, Speak,

And you will Connect.

Healing Occurs.

REFERENCES

- Appleby, L., Desai, P. N., Luchins, D. J., Gibbons, R. D., & Hedeker, D. R. (1993). Length of stay and recidivism in schizophrenia: A study of public psychiatric hospital patients. American Journal of Psychiatry, *150*, (1), 72-76.
- Appleby, L., Luchins, D., Desai, P., Gibbons, R., Janicak, P. G., & Marks, R. (1996). Length of inpatient stay and recidivism among patients with schizophrenia. Psychiatric Services, *47*, (9), 985-990.
- Arnstein, P., Caudill, M., Mandle, C. L., Norris, A. & Beasley, R. (1999). Self efficacy as a mediator of the relationship between pain intensity, disability and depression in chronic pain patients. Pain, *80*, (3), 483-491.
- Avison, W. R. & Speechley, K. N. (1987). The discharged psychiatric patient: A review of social, social-psychological, and psychiatric correlates of outcome. American Journal of Psychiatry, *144*, (1), 10-18.
- Azrin, N. H. & Teichner, G. (1998). Evaluation of an instructional program for improving medication compliance for chronically mentally ill outpatients. Behaviour Research and Therapy, *36*, 849-861.
- Baker, F. & Douglas, C. (1990). Housing environments and community adjustment of severely mentally ill persons. Community Mental Health Journal, *26*, 497-505.
- Bandura, A., Barbaranelli, C. Caprara, G. V., & Pastorelli, C. (1996). Multifaceted impact of self-efficacy beliefs on academic functioning. Child Development, *67*, 1206-1222.

Bandura, A. (1997). Self-Efficacy: The Exercise of Control. New York: W. H. Freeman and Company.

Bandura, A., Pastorelli, C. Barbaranelli, C. & Caprara, G. V. (1999). Self-efficacy pathways to childhood depression. Journal of Personality and Social Psychology, *76*, 258-269.

Birchwood, M. (1995). Early intervention in psychotic relapse: Cognitive approaches to detection and management. Behavior Change, *12*, 2-19.

Boss, P., Dahl, C., & Kaplan, L. (1996). The use of phenomenology for family therapy research: the search for meaning. In Sprenkle, D. H. & Moon, S. M. (Eds.) Research methods in family therapy (pp. 83-106). New York, NY: The Guilford Press.

Byers, E. S., & Cohen, S. H. (1979). Predicting patient outcome: The contribution of prehospital, inhospital, and posthospital factors. Hospital and Community Psychiatry, *30*, 327-331.

Carroll, K. M. (1996). Relapse prevention as a psychosocial treatment: A review of controlled clinical trials. Experimental and Clinical Psychopharmacology, *4*, (1), 46-54.

Davidson, L. Hoge, M. A., Merrill, M. E., Rakfeldt, J. & Griffith, E. E. H. (1995). The experiences of long-stay inpatients returning to the community. Psychiatry, *58*, 122-132.

Davidson, L., Stayner, D., Lambert, S., Smith, P., & Sledge, W. H. (1997). Phenomenological and participatory research on schizophrenia: Recovering the person in theory and practice. Journal of Social Issues, *53*, (4), 767-784.

DeHaan, L., Hawley, D. R. & Deal, J. E. (2002). Operationalizing family resilience: a methodological strategy. The American Journal of Family Therapy, 30, 275-291.

Erikson, W. C. & Paige, A. B. (1973). Fallacies of using length of stay and return rates as measures of success. Hospital and Community Psychiatry, 40, 559-561.

Faravelli, C., Ambonetti, A., Pallanti, S., & Passagli, A. (1986). Depressive relapses and incomplete recovery from index episode. American Journal of Psychiatry, 143, (7), 888-891.

Fava, G. A., Rafanelli, C. Cazzaro, M. Conti, S., & Grandi, S. (1998). Well-being therapy: a novel psychotherapeutic approach for residual symptoms of affective disorders. Psychological Medicine, 28, 475-480.

Fava, G. A., Rafanelli, C., Grandi, S., Canestrari, R., & Morphy, M. A. (1998). Six-year outcome for cognitive behavioral treatment of residual symptoms in major depression. American Journal of Psychiatry, 155, (10), 1443-1445.

Fava, G. A., Rafanelli, C., Grandi, S., Conti, S. & Bellluardo, P. (1998). Prevention of recurrent depression with cognitive behavioral therapy. Archives of General Psychiatry, 55, 816-820.

Fisher, W. H., Galler, J. L., Altaffer, F., & Bennett, M. B. (1992). The relationship between community resources and state hospital recidivism. American Journal of Psychiatry, 149, (3), 385-390.

Fontes, L A., Piercy, F., Thomas, V., & Sprenkle, D. (1998). Self issues for family therapy educators. Journal of Marital and Family Therapy, 24, (3), 305-320.

Frazier, S. R. & Casper, E. S. (1998). A comparative study of clinical events as triggers for psychiatric readmission of multiple recidivists. Psychiatric Services, *49*, (1), 1423-1425.

Friedmann, M. S., McDermt, W. H., Solomon, D. A., Ryan, C. E., Keitner, G. I. & Miller, I. W. (1997). Family functioning and mental illness: a comparison of psychiatric and nonclinical families. Family Process, *36*, 357-367.

Gladding, S. T. (1998). Family Therapy: History, Theory, and Practice. Upper Saddle River, CA. Prentice-Hall, Inc.

Gortner, E. T., Gollan, J. K., Dobson, K. S. & Jacobson N. S. (1998). Cognitive-behavioral treatment for depression: Relapse prevention. Journal of Consulting and Clinical Psychology, *66*, (2), 377-384.

Greenberg, W. M., Rosenfeld, D. N., & Ortega, E. A. (1995). Adjustment disorder as an admission diagnosis. American Journal of Psychiatry, *152*, (3), 459-461.

Hadley, T. R., Culhane, D. P., and McGurrin, M. C. (1992), Identifying and tracking “heavy users” of acute psychiatric inpatient services. Administration and Policy in Mental Health, *19*, 279-290.

Hall, G. B. and Nelson, G. (1996). Social networks, social support, personal empowerment, and the adaptation of psychiatric consumers/survivors: path analytic models. Social Science Medicine, *43*, (12), 1743-1754.

Hawley, D. R. & Dehaan, L. (1996). Toward a definition of family resilience: integrating life-span and family perspectives. Family Process, *35*, 283-298.

Haywood, T. W., Kravitz, H. M., Grossman, L. S., Cavanaugh, J. L., Davis, J. M., & Lewis, D. A., (1995). Predicting the “revolving door” phenomenon among patients

with schizophrenic, schizoaffective, and affective disorders. American Journal of Psychiatry, *152*, (6), 856-861.

Herman, N. J. (1993). Return to sender: Re-integrative stigma-management strategies of ex-psychiatric patients. Journal of Contemporary Ethnography, *22*, (3), 295-330.

Herz, M. I., & Lamberti, J. S. (1995). Prodromal symptoms and relapse prevention. Schizophrenia Bulletin, *21*, 541-550.

Hirsch, S. R., Platt, S., Knights, A., & Weyman, A. (1979). Shortening hospital stay for psychiatric care: Effect on patients and their families. British Medical Journal, *1*, 442-446.

Hiss, H., Foa, E. B., & Kozak, M.J. (1994). Relapse prevention program for treatment of obsessive-compulsive disorder. Journal of Consulting and Clinical Psychology, *62*, (4), 801-808.

Ho, A. P., Tsuang, J. W., Liberman, R. P., Wang, R., Wilkins, J. N., Eckman, T. A. & Shaner, A. L. (1999). Achieving effective treatment of patients with chronic psychotic illness and comorbid substance dependence. American Journal of Psychiatry, *156*, (11), 1765-1770.

Holahan, C. K. & Holahan, C. J. (1987^a). Self-efficacy, social support, and depression in aging: a longitudinal analysis. Journal of Gerontology, *42*, 65-68.

Illardi, S. S., Craighead, W. E., & Evans, D. D. (1997). Modeling relapse in unipolar depression: The effects of dysfunctional cognitions and personality disorders. Journal of Consulting and Clinical Psychology, *65*, (3), 381-391.

Ingram R. E., Miranda, J. & Segal, Z. V. (1998). Cognitive vulnerability to depression. New York, NY: The Guilford Press.

Irwin, J. E., Bowers, C. A., Dunn, M. E., & Wang, M. C. (1999). Efficacy of relapse prevention: A meta-analytic review. Journal of Consulting and Clinical Psychology, 67, (4), 563-570.

Jack, D. C. (1999). Silencing the self: inner dialogues and outer realities. In Joiner, T. & Coyne, J. C. (Eds.) The Interactional Nature of Depression. Washington, D. C.: American Psychological Association.

Johnson, E. (1998). The effect of family functioning and family sense of competence on people with mental illness. Family Relations, 47, 443-451.

Johnson, E. (2000). Differences among families coping with serious mental illness: A qualitative analysis. American Journal of Orthopsychiatry, 70, (1), 126-133.

Johnson, J. G., Han, Y, Douglas, C. J., Johannet, C. M., & Russell, R. (1998). Attributions for positive life events predict recovery from depression among psychiatric inpatients: an investigation of the Needles and Abramson model of recovery from depression. Journal of Consulting and Clinical Psychology, 66, (2), 369-376.

Kavanaugh, D. J. & Wilson, P. H. (1989). Prediction of outcome with group cognitive therapy for depression. Behavior Research Therapy, 27, (4), 333-343.

Kayser-Jones, J. & Koenig, B. A. (1994). Ethical issues. In Gubrium, J. F. & Sankar, A. (Eds.) Qualitative methods in aging research (pp. 15 – 32). Thousand Oaks, CA: Sage Pub.

Kendler, K. S., Thornton, L. M., & Prescott, C. A. (2001). Gender differences in the rates of exposure to stressful life events and sensitivity to their depressogenic effects. The American Journal of Psychiatry, *158*, 587-593.

Kent, S., Fogarty, M., & Yellowlees, P. (1995). A review of studies of heavy users of psychiatric services. Psychiatric Services, *46*, (12), 1247-1254.

Keitner, G. I., Ryan, C. E., Miller, I. W., Kohn, R., Bishop, D. S. & Epstein, N. B. (1995). Role of the family in recovery and major depression. American Journal of Psychiatry, *152*, (7), 1002-1008.

Klinkenberg, W. D., & Calsyn, R. J. (1996). Predictors of receipt of aftercare and recidivism among persons with severe mental illness: A review. Psychiatric Services, *47*, 487-496.

Kiser, D. F. & Piercy, F. P. (2001). Creativity and family therapy theory development: lessons from the founders of solution-focused therapy. Journal of Family Psychotherapy, *12*, (3), 1-30.

Kung, W. W. (2000). The intertwined relationship between depression and marital distress: elements of marital therapy conducive to effective treatment outcome. Journal of Marital and Family Therapy, *26*, (1), 51-63.

Laird, J. (1998). Theorizing culture: narrative ideas and practice principles. In M. McGoldrick (Ed.), Revisioning family therapy (pp. 20 – 36). New York, NY: The Guilford Press.

Larimer, M. E., Palmer, R. S., and Marlatt, G. A. (1999). An overview of Marlatt's cognitive-behavioral model. Alcohol Research and Health, *23*, (2), 151-160.

Leahy, R. L. & Holland, S. J. (2000). Treatment Plans and Interventions for Depression and anxiety Disorders. New York, NY: The Guilford Press.

Lieberman, P. B., Wiitala, S. A., Elliott, B., McCormick, S., & Goyette, S. B. (1998). Decreasing length of stay: Are there effects on outcomes of psychiatric hospitalization? American Journal of Psychiatry, *155*, (7), 905-909.

Lyons, J. S., O'Mahoney, M. T., Miller, S. I., Neme, J., Kabat, J., & Miller, F. (1997). Predicting readmission to the psychiatric hospital in a managed care environment: Implications for quality indicators. American Journal of Psychiatry, *154*, 337-340.

MacCormack, T. & Tomm, K. (1998). Social constructionist/narrative couple therapy. In F. M. Dattilio (Ed.), Case studies in couple and family therapy: systemic and cognitive perspectives (pp. 303 – 330). New York, NY: The Guilford Press.

Maciejewski, P. K., Prigerson, H. G., & Mazure, C. M. (2000). Self-efficacy as a mediator between stressful life events and depressive symptoms. British Journal of Psychiatry, *176*, 373-378.

Maxwell, J. A. (1996). Qualitative research design: an interactive approach. Thousand Oaks, Ca.: Sage Pub.

McFarlane, A. H., Bellissimo, A., & Norman, G. R. (1995). The role of family and peers in social self-efficacy: links to depression in adolescence. American Journal of Orthopsychiatry, *65*, (3), 402-410.

McFarlane, W. R., Lukens, E., Link, B., Dushay, R., Deakins, S. A., Newmark, M., Dunne, E. J., Horen, B., & Toran, J. (1995). Multiple-family groups and psychoeducation in the treatment of schizophrenia. Archives of General Psychiatry, *52*, 679-687.

McKay, J. R., Alterman, A. I., Cacciola, J. S., O'Brien, C. P., & Koppenhaver, J. M. (1999). Continuing care for cocaine dependence: Comprehensive 2-year outcomes. Journal of Consulting and Clinical Psychology, *67*, (3), 420-427.

Mead, D. E. (2002). Marital distress, co-occurring depression, and marital therapy: a review. Journal of Marital and Family Therapy, *28*, (3), 229-314.

Mesch, G. S. & Fishman, G. (1994). First readmission of the mentally ill: An event history analysis. Social Science Research, *23*, 295-314.

Miles, M. B. & Huberman, A. M. (1994). An expanded sourcebook: qualitative data analysis. Thousand Oaks, CA.: Sage Pub.

Muris, P., Bogie, N., & Hoogstedler, A. (2001). Effects of an early intervention group program for anxious and depressed adolescents: a pilot study. Psychological Reports, *88*, 481-482.

Muris, P., Schmidt, H., Lambrichs, R., & Meesters, C. (2001). Protective and vulnerability factors of depression in normal adolescents. Behaviour Research and Therapy, *39*, 555-565.

Newfield, N., Sells, S. P., Smith, T. E., Newfield, S., & Newfield, F. (1996). Ethnographic research methods: creating a clinical science of the humanities. In Sprenkle, D. H. & Moon, S. M. (Eds.). Research methods in family therapy (pp. 25 – 63). New York, NY: The Guilford Press.

Nichols, M. P. & Schwartz, R. C. (1995). Family Therapy: Concepts and Methods. Boston: Allyn and Bacon.

Nolen-Hoeksema, S. (1991). Responses to depression and their effects on the duration of depressive episodes. Journal of Abnormal Psychology, *100*, 569-582.

O'Farrell, T. J., Choquette, K. A. Cutter, H. S. G. Brown, E., Bayog, R. McCourt, W., Lowe, J., Chan, A. & Deneault, P. (1996). Cost-benefit and cost-effectiveness analyses of behavioral marital therapy with and without relapse prevention sessions for alcoholics and their spouses. Behavior Therapy, 27, 7-24.

Owen, C., Rutherford, V., Jones, M., Tennant, C., & Smallman, A. (1997). Psychiatric rehospitalization following hospital discharge. Community Mental Health Journal, 33, (1), 13-24.

Pages, K. P., Russo, J.E., Wingerson, D. K., Ries, R. K., Roy-Byrne, P. P., & Cowley, D. S. (1998). Predictors and outcome of discharge against medical advice from the psychiatric units of a general hospital. Psychiatric Services, 49, (9), 1187-1192.

Patterson, J. M. (2002). Integrating family resilience and family stress theory. Journal of Marriage and Family Therapy, 64, 349-360.

Phillips, J. M. & Gully, S. M. (1997). Role of goal orientation, ability, need for achievement, and locus of control in the self-efficacy and goal-setting process. Journal of Applied Psychology, 82, (5), 792-802.

Rafuls, S. E. & Moon, S. N. (1996). Grounded theory methodology in family therapy research. In Sprenkle, D. H. & Moon, S. M. (Eds.) Research methods in family therapy (pp. 64 – 82). New York, NY: The Guilford Press.

Reich, J. H. & Green, A. I. (1991). Effect of personality disorder on outcome of treatment. Journal of Nervous and Mental Disease, 179, 74-82.

Ryff, C. D., & Singer, B. Psychological well-being. Psychotherapy Psychosom, 65, 14-23.

- Sanguineti, V. R., Samuel, S. E., Schwartz, S. L., & Robeson, M. R. (1996). Retrospective study of 2,200 involuntary psychiatric admissions and readmissions. American Journal of Psychiatry, *153*, (3), 392-396.
- Schwartz, R. (1998). Internal family systems family therapy. In Dattilio, F. M. (Ed.). Case Studies in Couple and Family Therapy. (pp. 331-352). New York: The Guilford Press.
- Spiegel, D. & Wissler, T. (1986). Family environment as a predictor of psychiatric rehospitalization. American Journal of Psychiatry, *143*, (1), 56-60.
- Sprenkle, D. H. (2003). Effectiveness research in marriage and family therapy: introduction. Journal of Marital and Family Therapy, *29*, (1), 85-96.
- Stajkovic, A. D. & Sommer, S. M. (2000). Self-efficacy and causal attributions: direct and reciprocal links. Journal of Applied Social Psychology, *30*, (4), 707-737.
- Sullivan, G., Wells, K. B., Morgenstern, H., & Leake, B. (1995). Identifying modifiable risk factors for rehospitalization: A case-control study of seriously mentally ill persons in Mississippi. American Journal of Psychiatry, *152*, (12), 1749-1756.
- Sylvester, C.T. & Bean, G. J. (1989). Predicting community tenure after psychiatric hospitalization. Community Mental Health Journal, *25*, (2), 109-120.
- Teasdale, J. D. (1999). Emotional processing, three modes of mind and the prevention of relapse in depression. Behaviour Research and Therapy, *37*, S53-S77.
- Thomas, M. R., Rosenberg, S. A., Giese, A. A., Fryer, G. E., Dubovsky, S. L., & Shore, J. E. (1996). Shortening length of stay without increasing recidivism on a university-affiliated inpatient unit. Psychiatric Services, *46*, 996-998.

Walsh, F. (1996). The concept of family resilience: crisis and challenge. Family Process, 35, (3), 261-281.

Wan, T. H., & Ozcan, Y. A. (1991). Determinants of psychiatric rehospitalization: A social area analysis. Community Mental Health Journal, 27, (1), 3-16.

Westerberg, V. S. (1998). What predicts success? In W. R. Miller & N. Heather (Eds.), Treating Addictive Behaviors (pp. 301-315). (2nd ed.). New York: Plenum Press.

APPENDIX A
LETTER OF RECRUITMENT

Catherine B. Thorne, LCSW
Psychiatric Lead of Clinical Services
Carilion Roanoke Memorial Hospital
Rehabilitation Center
Jefferson St. at McClanahan St.
Roanoke, Va. 24014

Dear _____:

During a recent admission while hospitalized at the Carilion Roanoke Memorial Hospital Rehabilitation Center you filled out an evaluation of the services you received there and signed permission for a follow-up contact with someone from the hospital. I am the Psychiatric Lead for Clinical Services there and I am also a candidate for the Ph.D degree in the Department of Family and Child Development at Virginia Tech.

While you were hospitalized you participated in the clinical groups on relapse prevention. In order to further facilitate the well-being of our patients, I am contacting you to offer you and if you so choose, your family, an opportunity to participate in a research project designed to help us better understand the needs of our patients once they have been discharged into the community, what their experiences have been in preventing relapse and seeking mental health, and what has contributed to the status of their mental health.

Participation would involve the opportunity to tell your story about your post-discharge experiences of pursuing well-being in an in-depth interview with myself, followed by a second interview with myself to clarify any misconceptions and lastly a focus group facilitated by myself consisting of yourself and other participants in the project who were also discharged from the hospital, so that you may have an opportunity to share with others and to hear from others what your and their experiences have been.

For the purposes of facilitating accuracy of information, I am requesting that all of these sessions will be videotaped. The videotapes will be kept in my office under lock and key and will remain confidential, with no one having access to them other than myself. I am also requesting that you sign a release of information giving me permission

to contact your outpatient therapist and/or psychiatrist for further information that might be helpful in understanding your experiences in promoting relapse prevention and well-being.

Once you have received this letter, I will follow-up with a phone call to clarify any questions you may have about the project and to determine if you are interested in participating. It is my sincere hope that the information provided by this opportunity will help us better serve our patients. Thank you for your consideration of this matter. I will look forward to contacting you soon.

Sincerely,

Catherine B. Thorne, LCSW
Psychiatric Lead of Clinical Services

APPENDIX B

CARILION ROANOKE MEMORIAL HOSPITAL REHABILITATION CENTER Informed Consent for Participants of Investigative Projects

Title of Project: Journeys Toward Wholeness: Stories of Lived Experience of Patients and Their Families Pursuing Mental Health After Psychiatric Hospitalization

Principal Investigator: Catherine B. Thorne, LCSW; Researcher, Psychiatric Lead of Clinical Services, Carilion Roanoke Memorial Hospital Rehabilitation Center, (540) 981-7447.

I. The Purpose of the Research Project

You are invited to participate in a study of patients who have been discharged from the Carilion Roanoke Memorial Hospital Rehabilitation Center. The purpose of this research project is to help us better understand the needs of patients once they have been discharged into the community, what their experiences have been in preventing relapse and seeking mental health, and what they feel has contributed to their mental health. Information gathered from this project will be used to revise our clinical programs of individual, group, and family therapy to better accommodate the needs of patients.

II. Procedures

Approximately ten former patients will participate in individual two-hour videotaped and/or audiotaped interviews at a mutually convenient location, followed by a second videotaped and/or audiotaped interview of shorter duration to clarify any misconceptions and seek further information. Lastly you will participate in a videotaped and/or audiotaped focus group consisting of all former patients participating in the study. After each interview you will be sent a copy of the results of the interview to determine if you agree with the results as representative of the interview or if there are other thoughts about the interview that you would like to add. Each interview will focus on what your experiences have been since discharge from the hospital, how your mental health has been promoted or hindered, whether relapse prevention principles have helped promote mental health, what role family members and significant others have played in relapse prevention, and what you believe would have been helpful for you to have learned in the relapse prevention program while hospitalized. The whole research process should last approximately three months.

In addition, you will be asked to sign a release of information that gives the researchers permission to contact your outpatient therapist or psychiatrist for information that might be helpful in this study. The release will allow the researcher to receive a copy of your hospital and therapy records.

III. Risks

There is a risk that talking about your experiences may be difficult for you emotionally or psychologically. It is possible you might wish to talk in a therapeutic setting about issues uncovered in the research process. If that happens you will be referred to a counselor.

The primary risk of this study involves potential breaches of confidentiality of sensitive information. Personal data will be collected from interviews, in notes taken by the researcher, and from hospital records and records of therapy. You will be asked to sign separate consent forms to give the researcher permission to gather some of this information.

IV. Benefits of the Research Project

Your participation in this project will help the clinical staff know how to revise the program to better serve the needs of patients. There is no guarantee of personal benefit for yourself; however, it is the hope of the researcher that the opportunity to participate in this research will in itself be rewarding to you. When the research is completed, you will be sent a summary of the research findings.

V. Extent of Anonymity and Confidentiality

The researcher will take steps to protect disclosure of any personal information by keeping it in a locked cabinet in a secure office. Identifying information that could link sensitive data to you will be destroyed after the initial phase of the research is complete. However, complete confidentiality cannot be guaranteed. Research related persons overseeing research at Carilion Medical Center and Virginia Tech might review records. Also, state law mandates that information relating to child or elder abuse or neglect be reported to proper authorities. Behavioral researchers have an ethical obligation to report the intention of a subject to harm himself or herself or intention of a subject to harm others. In addition, it is possible that some information could be required under subpoena or court order. Examples where subpoenas or court orders might be used include divorce or custody disputes or criminal activities.

Interviews and focus groups will be videotaped and/or audiotaped to facilitate accuracy of information. All videotapes and/or audiotapes will be kept under lock and key and will be coded by numbers rather than by name. The videotapes and/or audiotapes will remain confidential. No one will have access to the videotapes other than the researcher and no one will have access to the audiotapes other than the researcher and research assistant. After the research process is complete, the videotapes and/or audiotapes will be destroyed.

The interviews will be transcribed into written format by the researcher and/or research assistant. Fictitious names will be given to all participants. Transcripts will not be released to anyone other than researchers working on this project without your written consent. Any information in the transcripts that could lead to your identification will be

deleted. Transcripts will be kept in a locked cabinet in a secure office. Research data may be kept up to two years before being destroyed.

If data or information from the study is submitted for publication in a professional journal or is presented at a professional meeting, your identity will not be revealed.

VI. Alternatives

This study is not a form of treatment and there are no alternative methods of participation in this study.

VII. Compensation and Cost

There is no charge for participating in this study. Also, you will not be paid for your participation.

VIII. Freedom to Withdraw

Your participation in this study is voluntary. You are free to withdraw from this study at any time without penalty. You are also free not to answer any questions that you prefer not to answer without penalty. If you choose to withdraw you may do so by notifying the researcher.

The researcher can remove you from the study for any reason without your consent if the researcher feels it is in your best interest. The reason for removal will be explained to you.

IX. Financial Considerations:

This is an independent study without sponsors or funding and the researcher will receive no financial compensation.

X. Approval of Research

This research project has been approved, as required, and will be overseen by the Institutional Review Board for Research Involving Human Subjects at Virginia Polytechnic Institute and State University, by the Department of Family and Child Development, and by the Carilion Medical Center Institutional Review Board.

VPS-SU IRB Approval Date

Approval Expiration Date

Carilion Medical Center IRB
Approval Date

Approval Expiration Date

XI. Participant Responsibilities

It is the responsibility of the participant to answer all questions asked honestly and to the best of the participant's ability, or to refuse to answer any questions or withdraw from the interview if the participant chooses to do so. It is the responsibility of the participant to inform the researcher if he or she wishes to see a therapist and is not currently in therapy. It is the responsibility of the participant to keep confidential any and all information about other participants and their comments learned from participation in the focus group.

XII. Contact Persons

If you have questions about your rights as a research subject, you may contact James E. Foster, MD, Chair of the Carilion Medical Center Institutional Review Board at (540) 981-7590. If you have any questions or concerns about the study, you may contact the researcher or her immediate supervisors Dr. Richard W. Seidel and Dr. Scott W. Johnson during the day at the numbers listed below.

Catherine B. Thorne, MSW, LCSW; Researcher (540) 981-7447
Psychiatric Lead of Clinical Services
Carilion Roanoke Memorial Rehabilitation Center

Richard W. Seidel, Ph. D. (540) 981-7778
Director of Clinical Programs
Carilion Roanoke Memorial Rehabilitation Center

Scott W. Johnson, Ph.D., Faculty Adviser (540) 231-3311
Department of Human Development
Virginia Polytechnic Institute and State University

Joyce A. Arditti (540) 231-5758
Departmental Reviewer
Department of Human Development
Virginia Polytechnic Institute and State University

David M. Moore (540) 231-4991
Chair, Institutional Review Board
Office of Research Compliance
Research and Graduate Studies
Virginia Polytechnic Institute and State University

XIII. Participant's Permission

I have read the Informed Consent and have had all my questions answered. I agree to participate in this research project and to abide by the rules of the project. If at a later

date I have any further questions or concerns I may contact the researcher or her supervisors as listed above.

Signature of Participant

Date

Signature of Person Obtaining Signature

Date

Signature of Researcher

Date

APPENDIX D

POTENTIAL THEMES TO GUIDE INTERVIEW

Self-efficacy beliefs

Personal goals

Helplessness

Relapse prevention skills

Depression and symptoms

Dominant stories

Alternative stories

Internalized communities

Cultural narratives

Family/social support

Social isolation

Medication compliance

Substance Abuse

Unrealistic expectations

Negative thinking

Rumination or worrying

Causal attributions

Loss

Hopelessness

Aftercare

Level of functioning

Family efficacy

Coping skills

Outcome expectancies

Relapse

Well-being

Emotional processing

Stressful life events: independent and dependent

APPENDIX E

IN-DEPTH INTERVIEW GUIDE

Begin with thanking the participant for participating in this research and review and sign Informed Consent forms.

The following questions are guidelines. Initial questions are open-ended and will be based on the research questions. If appropriate, probing and follow-up questions will be asked in response to the answers to the open-ended questions.

What was your experience in leaving the hospital and continuing to work on your own mental health goals as an outpatient?

How confident were you of your ability to help yourself get better and how has that changed since your discharge?

What did you expect to have happen?

What things helped you to or hindered you from getting better?

What role did your family play in supporting you or hindering you in getting better?

What were the symptoms you were experiencing in the hospital and how have these symptoms changed?

What kind of social support do you have and how has that changed since hospitalization?

Now that you have been out of the hospital for a while, what suggestions would you make to the hospital that would help improve their clinical program in preparing patients for discharge?

If family members are present, rephrase questions to incorporate perspective of the participating family member and to assess family efficacy.

When the interview is complete, review the research process with the participant and offer to answer any questions they may have about the process. Thank the participant for their cooperation.

APPENDIX F

FOCUS GROUP INTERVIEW GUIDE

Begin with thanking the participants for coming to the group and review Informed Consent forms.

Have group introduce themselves to each other by first name only.

Ask open-ended questions for group discussion:

Since leaving the hospital, what has been your experience in getting better?

What has helped you to get better or hindered you from getting better?

How has your confidence about your mental health changed since hospitalization?

What role have family and friends played in supporting you or hindering you?

What suggestions would you make to the hospital that would help improve their clinical program in preparing patients for discharge?

APPENDIX G

CONSENT TO BE VIDEOTAPED AND/OR AUDIOTAPED

With your permission, you will be videotaped and/or audiotaped as part of a research project being conducted by Catherine B. Thorne, LCSW. Your name or personal information will not be recorded on the videotape and/or audiotape, and confidentiality will be strictly maintained.

The researcher will keep the videotape(s) and/or audiotapes in a locked cabinet. The only persons who will be allowed to see the videotapes are the researcher and her immediate supervisors, Richard W. Seidel, Ph.D. and Scott W. Johnson, Ph.D. and the only persons who will be allowed to hear the audiotapes are the researcher, the research assistant, and the researcher's immediate supervisors, Richard W. Seidel, Ph.D. and Scott W. Johnson, Ph.D. The videotapes and/or audiotapes will be used to help make sure information in the study is accurate. Once the videotapes and/or audiotapes are no longer needed to assure the accuracy of information in the study, they will be destroyed.

I give my permission to be videotaped and/or audiotaped solely for this research project under the conditions described above.

(Signature) _____

(Date) _____

APPENDIX H

CONSENT TO RELEASE/REVIEW MEDICAL INFORMATION

I, the undersigned, do hereby authorize and request the following facilities

(Name of Facility)

(Name of Facility)

(Name of Facility)

(Name of Facility)

to release the complete medical record information of:

Patient Name: _____

Date of Birth: _____ Social Security Number _____

Phone Number _____ Treatment Date(s) _____

to _____ of the Journeys Toward Wholeness research project.
(Name of staff person)

This disclosure is for the purpose of my participation in the Journeys Toward Wholeness research project sponsored by Carilion. You may contact the office of the researcher, Cathy Thorne (540-981-7447) with any questions or concerns.

These records are confidential and may be disclosed only as authorized in this consent or required by law. I also understand that this consent is revocable by me at any time except that action has been taken in reliance on this consent. Unless an earlier date is specified, this consent automatically expires one year after the day below.

Duplication of this document shall have the same force and effect as the original.

SIGNATURE _____ DATE - _____
(Signature of the Patient/Parent/Legal Guardian)

(Relationship to Patient)

APPENDIX I

CARILION ROANOKE MEMORIAL HOSPITAL REHABILITATION CENTER Informed Consent for Family/Significant Other of Participants of Investigative Projects

Title of Project: Journeys Toward Wholeness: Stories of Lived Experience of Patients and Their Families Pursuing Mental Health After Psychiatric Hospitalization

Principal Investigator: Catherine B. Thorne, LCSW; Researcher, Psychiatric Lead of Clinical Services, Carilion Roanoke Memorial Hospital Rehabilitation Center, (540) 981-7447.

I. The Purpose of the Research Project

You are invited to participate in a study of patients who have been discharged from the Carilion Roanoke Memorial Hospital Rehabilitation Center. You are being asked to participate in the project because a former patient feels that you would be helpful in the interview process. The purpose of this research project is to help us better understand the needs of patients once they have been discharged into the community, what their experiences have been in preventing relapse and seeking mental health, and what they feel has contributed to their mental health. Information gathered from this project will be used to revise our clinical programs of individual, group, and family therapy to better accommodate the needs of patients.

II. Procedures

Approximately ten former patients and their invited family members/significant others will participate in individual two-hour videotaped and/or audiotaped interviews at a mutually convenient location, followed by a second videotaped and/or audiotaped interview of shorter duration to clarify any misconceptions and seek further information. Lastly they will participate in a videotaped and/or audiotaped focus group consisting of all former patients participating in the study. Each interview will focus on what their experiences have been since discharge from the hospital, how their mental health has been promoted or hindered, whether relapse prevention principles have helped promote mental health, what role family members and significant others have played in relapse prevention, and what you believe would have been helpful for them to have learned in the relapse prevention program while hospitalized.

In addition, you will be asked to sign a release of information that gives the researchers permission to contact your outpatient therapist or psychiatrist for information that might be helpful in this study. The release will allow the researcher to receive a copy of your hospital and therapy records.

III. Risks

There is a risk that talking about your experiences may be difficult for you emotionally or psychologically. It is possible you might wish to talk in a therapeutic setting about issues uncovered in the research process. If that happens you will be referred to a counselor.

The primary risk of this study involves potential breaches of confidentiality of sensitive information. Personal data will be collected from interviews, in notes taken by the researcher, and from hospital records and records of therapy. You will be asked to sign separate consent forms to give the researcher permission to gather some of this information.

IV. Benefits of the Research Project

Your participation in this project will help the clinical staff know how to revise the program to better serve the needs of patients. There is no guarantee of personal benefit for yourself; however, it is the hope of the researcher that the opportunity to participate in this research will in itself be rewarding to the former patient.

V. Extent of Anonymity and Confidentiality

The researcher will protect disclosure of any personal information by keeping it in a locked cabinet in a secure office. Identifying information that could link sensitive data to you will be destroyed after the initial phase of the research is complete. However, complete confidentiality cannot be guaranteed. Research related persons overseeing research at Carilion Medical Center and Virginia Tech might review records. Also, state law mandates that information relating to child or elder abuse or neglect be reported to proper authorities. Behavioral researchers have an ethical obligation to report the intention of a subject to harm himself or herself or intention of a subject to harm others. In addition, it is possible that some information could be required under subpoena or court order. Examples where subpoenas or court orders might be used include divorce or custody disputes or criminal activities.

Interviews and focus groups will be videotaped and/or audiotaped to facilitate accuracy of information. All videotapes and/or audiotapes will be kept under lock and key and will be coded by numbers rather than by name. The videotapes and/or audiotapes will remain confidential. No one will have access to the videotapes other than the researcher and no one will have access to the audiotapes other than the researcher and research assistant. After the research process is complete, the videotapes and/or audiotapes will be destroyed.

The interviews will be transcribed into written format by the researcher and/or research assistant. Fictitious names will be given to all participants. Transcripts will not be released to anyone other than researchers working on this project without your written consent. Any information in the transcripts that could lead to your identification will be

deleted. Transcripts will be kept in a locked cabinet in a secure office. Research data may be kept up to two years before being destroyed.

If data or information from the study is submitted for publication in a professional journal or is presented at a professional meeting, your identity will not be revealed.

VI. Alternatives

This study is not a form of treatment and there are no alternative methods of participation in this study.

VII. Compensation and Cost

There is no charge for participating in this study. Also, you will not be paid for your participation.

VIII. Freedom to Withdraw

Your participation in this study is voluntary. You are free to withdraw from this study at any time without penalty. You are also free not to answer any questions that you prefer not to answer without penalty. If you choose to withdraw you may do so by notifying the researcher.

The researcher can remove you from the study for any reason without your consent if the researcher feels it is in your best interest. The reason for removal will be explained to you.

IX. Financial Considerations:

This is an independent study without sponsors or funding and the researcher will receive no financial compensation.

X. Approval of Research

This research project has been approved, as required, and will be overseen by the Institutional Review Board for Research Involving Human Subjects at Virginia Polytechnic Institute and State University, by the Department of Family and Child Development, and by the Carilion Medical Center Institutional Review Board.

VPS-SU IRB Approval Date

Approval Expiration Date

Carilion Medical Center IRB
Approval Date

Approval Expiration Date

XI. Participant Responsibilities

It is the responsibility of the participant to answer all questions asked honestly and to the best of the participant's ability, or to refuse to answer any questions or withdraw from the interview if the participant chooses to do so. It is the responsibility of the participant to keep confidential any and all information about other participants and their comments learned from participation in the focus group.

XII. Contact Persons

If you have questions about your rights as a research subject, you may contact James E. Foster, MD, Chair of the Carilion Medical Center Institutional Review Board at (540) 981-7590. If you have any questions or concerns about the study, you may contact the researcher or her immediate supervisors Dr. Richard W. Seidel and Dr. Scott W. Johnson during the day at the numbers listed below.

Catherine B. Thorne, MSW, LCSW; Researcher (540) 981-7447
Psychiatric Lead of Clinical Services
Carilion Roanoke Memorial Rehabilitation Center

Richard W. Seidel, Ph. D. (540) 981-7778
Director of Clinical Programs
Carilion Roanoke Memorial Rehabilitation Center

Scott W. Johnson, Ph.D., Faculty Adviser (540) 231-3311
Department of Human Development
Virginia Polytechnic Institute and State University

Joyce A. Arditti (540) 231-5758
Departmental Reviewer
Department of Human Development
Virginia Polytechnic Institute and State University

David M. Moore (540) 231-4991
Chair, Institutional Review Board
Office of Research Compliance
Research and Graduate Studies
Virginia Polytechnic Institute and State University

XIII. Participant's Permission

I have read the Informed Consent and have had all my questions answered. I agree to participate in this research project and to abide by the rules of the project. If at a later date I have any further questions or concerns I may contact the researcher or her supervisors as listed above.

Signature of Participant

Date

Signature of Person Obtaining Signature

Date

Signature of Researcher

Date

CURRICULUM VITAE

Catherine B. Thorne
7000 Fairpines Rd.
Chesterfield, VA 23832
(804) 743-1077 Home

OBJECTIVE

To work in a behavioral health setting practicing therapy for individuals, couples, and families; and teaching, training and supervising staff in essential therapeutic skills.

EDUCATION

DOCTOR OF PHILOSOPHY CANDIDATE
Virginia Polytechnic Institute and State University
Blacksburg, Virginia
Marriage and Family Therapy, Expected Graduation Date Fall 2003

MASTER OF SOCIAL WORK, May 1980
Virginia Commonwealth University, Richmond, Virginia

BACHELOR OF ARTS, May 1971
University of North Carolina, Chapel Hill, North Carolina
Psychology and Sociology

PROFESSIONAL EXPERIENCE: THERAPY

1999 – 2003 PSYCHIATRIC LEAD FOR CLINICAL SERVICES
Carilion Roanoke Memorial Hospital, Roanoke, Virginia

Duties: Supervise and coordinate administrative needs of clinical staff.
Coordinate therapeutic services for individuals, couples, families, and groups.
Perform duties of clinical social worker.
Supervise undergraduate interns.
Provide supervision towards licensure.
Coordinate revision of group program.
Organize, supervise, and lead staff inservices.
Participate in program development and revision.
Provide lectures and train medical students and residents in therapeutic skills of assessment and treatment with emphasis on couple and family therapy.

1996 - 1999 CLINICAL SOCIAL WORKER
Carilion Roanoke Memorial Hospitals, Roanoke, Virginia

Duties: Provided therapy for individuals, couples, families and groups working as

part of an interdisciplinary treatment team to assess and develop appropriate treatment and discharge plans for participants.

1993 – 1994 STUDENT THERAPIST

Center for Family Services
Virginia Polytechnic Institute and State University
Blacksburg, Virginia

Duties: Provided therapy for individuals, couples, and families.

1991 - 1993 MEDICAL SOCIAL WORKER

Community Dialysis Center, Martinsville, Virginia

Duties: Provided therapeutic services including assessment and treatment with individual patients and families.
Advocated for patient needs with other agencies.
Provided discharge planning.
Participated in interdisciplinary treatment team meetings.
Conducted home assessments.

1992 – 1993 VOLUNTEER COUNSELOR

Mental Health Association, Martinsville, Virginia

Duties: Provided individual, couple and family therapy.
Led “Beyond Divorce” recovery groups.

1992 COUNSELOR

Associates in Cognitive Therapy Services, Roanoke, Virginia

Duties: Provided individual and couples therapy.

1990 – 1991 SENIOR CLINICIAN IN PREVENTION

Chesterfield Community Services Board for Mental Health, Mental Retardation, and Substance Abuse, Chesterfield, Virginia

Duties: Led “Beyond Divorce” recovery groups for adults and junior high students.
Led COA groups for junior high students.

1980 – 1981 SOCIAL WORKER FOR OUTREACH SERVICES FOR OLDER PEOPLE

Family Services of Roanoke Valley, Roanoke, Virginia

Duties: Performed advocacy work for elderly.
Provided counseling.
Assessed needs for human services and provided access to those services.

1979 – 1980 PRACTICUM SOCIAL WORKER

Children's Home Society of Virginia, Roanoke, Virginia

Duties: Conducted home studies of adoptive parents.

Led groups for teenage mothers with emphasis on empowerment issues.

1980 PRACTICUM SOCIAL WORKER

Roanoke Valley Mental Health Services, Roanoke, Virginia

Duties: Co-lead family therapy sessions.

1978 – 1979 PRACTICUM PEDIATRIC MEDICAL ONCOLOGY SOCIAL WORKER

Sidney Farber Cancer Institute, Boston, Mass.

Duties: Provided counseling for families of pediatric cancer patients.

Co-lead grief group for families of deceased patients.

1973 – 1977 SOCIAL WORKER

Danvers Twin Oaks Nursing Home, Danvers, Mass.

Duties: Counseled with patients and families.

Led patient support group.

Supervised field education student chaplains.

Provided discharge planning.

PROFESSIONAL EXPERIENCE: EDUCATION

1998 – 2003 GUEST LECTURER IN PSYCHIATRY PROGRAM

University of Virginia Training Centers, Roanoke, Virginia

Duties: Taught Medical Students since 1998 about marital and family therapy.

Taught Residents since 2000 about family therapy.

Summer 1995 – Spring 1998 ADJUNCT PROFESSOR

Virginia Polytechnic Institute and State University, Blacksburg, Virginia

Duties: Taught "Family Law and Public Policy" Spring 1998, Fall 1997, Fall 1996

Taught "Families and Children Under Stress", Spring 1997, Fall 1996

Taught "Principles of Human Services" Summer 1995, Summer 1996

Fall 1994, Spring and Fall 1995 TEACHING ASSISTANT

Virginia Polytechnic Institute and State University, Blacksburg, Virginia

Duties: Taught "Principles of Human Services"

1993 –1994 PREVENTION EDUCATOR

New River Valley Community Service Board: Community Education and Prevention Services, Christiansburg, Virginia

Duties: Designed and taught parent education classes at New River Valley Head Start

1989 – 1991 CONSULTANT FOR REVITALIZATION AND EVANGELISM

Petersburg District of the Virginia United Methodist Conference, Petersburg, Virginia

Duties: Conducted workshops on long range planning and on various church growth topics.

PROFESSIONAL EXPERIENCE: RESEARCH

2001 – 2003 DISSERTATION RESEARCH

Virginia Polytechnic Institute and State University
Carilion Roanoke Memorial Hospital

Duties: Principal Investigator of research study entitled: Managing Depression: Stories of Patients and their Families Pursuing Mental Health After Psychiatric Hospitalization.

Scheduled date for defense of dissertation: September 17, 2003

SPRING 1996 RESEARCH ASSISTANT

Virginia Polytechnic Institute and State University, Blacksburg, Virginia

Duties: Participated in development and implementation of survey of graduates of the Department of Family and Child Development. Focused on issues of evaluation and sustainability of family service programs.

FALL 1992 GRANT WRITER

Piedmont Regional Community Service Board, Martinsville, Virginia

Duties: Co-wrote grant for funding from the Virginia Department of Youth.

SKILLS

THERAPEUTIC SKILLS:

KNOWLEDGE: Includes Systems Family Therapy, specializing in Cognitive Behavioral, Narrative, Solution Focused, and Intergenerational therapy, with training in Structural, Strategic, and Experiential therapy.

SPECIFIC AREAS OF EXPERTISE: Practice involves use of intake, assessment, diagnosis, treatment, and evaluation procedures. Includes familiarity

with psychiatric diagnoses and mental health issues such as relapse prevention; depression; suicidality; sexual, physical, and verbal abuse; anxiety; paranoia and self esteem; substance abuse; marital and family dynamics issues such as conflict resolution, communication, sexuality, and intimacy; and spiritual issues; health and illness issues such as terminal care, rehabilitation, institutional placement, and grief; life course issues such as problems of elderly, adoption issues for infant and older child placement, teenage motherhood, career development, and separation and divorce.

CLIENT CONTACTS: Includes working with individual clients of all ages, couples, and families and working with groups.

TEACHING SKILLS:

KNOWLEDGE: Includes preparation of syllabus, lectures, workshops, and speeches, incorporating outside resources, grading, evaluation, and supervision of interns.

EXPERIENCE: Lectures to medical students and residents in a hospital setting, teaching several courses to undergraduate college students, and leading workshops.

ADMINISTRATIVE SKILLS:

KNOWLEDGE: Includes principles of employee management, incorporating recruitment, training, motivation, supervision and coordination of employee work needs.

PRACTICE: Currently involves assistant management of clinical staff, including licensed and unlicensed therapists and recreational therapists.

RESEARCH SKILLS:

KNOWLEDGE: Includes basic research courses on qualitative and quantitative methods of research.

EXPERIENCE: Currently finishing research for completion of Ph.D. in Marriage and Family Therapy. Scheduled to defend September 17, 2003.

PRESENTATIONS

Thorne, Catherine B. (2003). Relapse Prevention: Initial Results of a Follow-up Study of Patients Discharged From Inpatient Treatment. Carilion Roanoke Memorial Rehabilitation Center Clinical Rounds presentation.

Thorne, Catherine B. (1995). The Use of Clinical Narrative to Promote Intimacy in Parent-Child Relationships. Paper presented at the Southeastern Council on Family Relations. Annual Meeting, Atlanta Families Conference '95, Atlanta, Georgia.

Thorne, Catherine B. (1994). A Proposed Study of Separated Couples Who Reconcile. Paper presented at the Southeast Symposium on Child and the Family, Quint State Conference, Knoxville, Tennessee

CONFERENCES AND WORKSHOPS ATTENDED

“Resolving Ethical Dilemmas: A Focus on Mental Competence and Decisional Capacity” with Dr. Bruce Corsino. March 27, 2003.

25th Psychotherapy Networker Symposium. March 8 – 10, 2002

24th Psychotherapy Networker Symposium. March 23 – 25, 2001

23rd Psychotherapy Networker Symposium. April 28 – 29, 2000

“Post-Traumatic Stress Disorder,” and “Obsessive-Compulsive Disorder,” October 1 - 2, 1998 by Institute for Behavioral Healthcare with Edna B. Foa, PhD.

“Narrative Ideas and Therapeutic Practice,” June 5 – 6, 1998 by Stephen Madigan, PhD.

American Association of Marriage and Family Therapy 55th Annual Conference, September 18 – 21, 1997.

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