The Stories of Women Living with Depression:

Their Coping Strategies and Resources

A report presented to the Maritime Centre of Excellence by The Canadian Mental Health Association, Nova Scotia Division, by Jean Hughes, Principal Investigator and Cathy McCormack, Project Coordinator
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Executive Summary

Little is known about the recovery and coping experience of women living with depression aside from the fact that the process seems to be easier for women who are older when depression is first experienced and have positive family relationships, no concurrent illness and few stressful life events. The "Stories of Women Living with Depression" study examined the coping and recovery processes of women of low-income status at-risk for/experiencing depression. Specifically, it explored the personal coping strategies used to assist women in meeting the demands of everyday life in family, social and work settings. This exploratory study employed the experiential expertise of mental health consumers (those who have experienced depression) in gathering women's perspectives on well-being, health practices and coping strategies used to manage and recover from depression.

The study invited women to participate who were between 20 and 40 years of age and attended Cowie Family Medicine Centre during a five-month period. Out of the 40 women recruited for the study, 21 (50%) were eligible for an interview. The first 15 eligible women were interviewed. Women who consented were first screened for depressive symptoms. Those who were found to be at-risk and wished to continue with the study were then contacted for an in-depth interview. Women participating in the study were interviewed in person using a semi-structured interview guide. The interview guide was designed with input from mental health consumers and these same women conducted the interviews. Interviews focused on encouraging women to discuss their perceptions of different levels of well-being (healthy, "the blues", depression), strategies and resources needed, and barriers to overcome. Particular attention was given to factors that build capacity, strengthen coping mechanisms and enhance family, social and work life (paid or volunteer).

Data collection included a demographic form addressing known socio-cultural factors related to depression, the Centre for Epidemiological Studies Depression Scale (CES-D), the Difficult Life Circumstances Scale, and a semi-structured interview guide. Once completed, the interviews were transcribed and submitted for thematic analysis. Results showed that (a) women's perceptions of health, the 'blues', and depression were distinct; (b) women used different strategies, supports and resources to cope with health, the 'blues' and depression; (c) women's interactions at home, work and in social life varied according to their level of well-being; (d) strategies and resources fit the specific needs and capacities available for each level of well-being; and (e) despite socio-economic disadvantage, money was not the major stressor for most women.

The Stories of Women Living with Depression: Their Coping Strategies and Resources

1.0 Summary of the Research Project

1.1 Goals and Objectives

Goal: To generate a knowledge base and gain an enhanced understanding about the coping and recovery processes associated with depression of women of low-income status.

Objectives:

- Record the stories of women who are at-risk for or experiencing depression.
- Examine the effects of setting (home, social, work) on the experience of depressive symptoms/depression.
- Describe the personal coping strategies and resources (informal and formal supports) women use during the coping and recovery process to strengthen their mental health capacity.
- Identify the process women use in making decisions about accessing informal supports and formal resources

1.2 Current Knowledge about Depression

Depression is a complex phenomenon that varies considerably. It is estimated that 5 –10% of women in the Western world experience this disorder, and that women have an overall lifetime risk of 20%-25% for depression – about twice as much as men.[32] Women between the ages of 20 and 40 years are at greatest risk for depression. This risk increases for women who have a family history of depression, poor coping skills, poor self-esteem, low income or no employment or working with poor child care, low education, are survivors of violence, lack support, and have young children (under the age of 7 years).[4] What is not clear is whether these risk factors influences depression as a cause or an aggravation. Depression has strong links with other illnesses (e.g., heart disease, stroke, diabetes, HIV/AIDS) and substance disorders (e.g., alcoholism).

Depression affects all aspects of life, in the home (housekeeping, parenting), at work (concentration, organization, problem-solving), and during social activities (connecting with friends). And the cost of depression is extremely high in terms of medical care, worker absenteeism and reduced productivity ($3 billion every year in Canada).[33] The costs to personal satisfaction and family functioning (family conflict, antisocial behaviour, poor interpersonal relationships, decline in quality of life, substance use problems, physical illness, death) are incalculable. Although treatable, many women do not seek help and/or take years to get appropriate assistance.

Women who have depression experience a number of emotional symptoms (anxiety, helplessness, hopelessness, concentration difficulties, guilt, thoughts of suicide) and physical symptoms (lethargy, change in appetite, change in weight, sleep disturbances) that can vary in level of intensity and duration anywhere from a few days to years.[4] Those women who experience symptoms that are relatively mild, of short duration (less than 2 weeks) and generally not recurrent are said to have what many people call the 'blues'. Those women who experience symptoms that are severe, prolonged (more than 2 weeks) and generally recurring are said to have a medical diagnosis of clinical depression.

Women who experience relatively mild depression (e.g., following a disappointment) or situational depression (e.g., following a stressful event) are often able to manage the sadness and continue their daily living without significant interruption, even when the depressed mood lasts for several months. However, those women who experience a major depressive disorder experience a significant disruption in their personal activities of daily living and social relationships (e.g., loss of interest or pleasure in nearly all activities).

Little is known about the recovery and coping experience of women living with depression aside from the fact the process seems easier for women who are older when depression is first experienced and who have positive family relationships, no concurrent illness and few stressful life events.[14] Depression is a major health problem. Indeed, evidence indicates that the lifetime prevalence rate of clinically significant depression ranges from 15% to 30%, and the point-in-time prevalence rate of clinically significant depression ranges from 3.5% to 27% in the general population.[4,13,21]

Women are twice as likely to experience depression as men[10,13] especially if they are between the ages of 20 and 40 years.[4,13,16] This is a time in life when women are faced with multiple pressures from marriage/significant relationships, child rearing, extended family, work and social networks. The challenge of juggling these pressures can generate feelings of depression in women who bear the majority of burden of responsibility for family and home. The possibility of depression becomes even greater for women who experience certain personal, and social/environmental characteristics. That is, women are more vulnerable to depression if they have a personal/family history of depression, poor coping skills, low self-esteem, are socio-economically and educationally disadvantaged, are victims of violence, lack support, and have children below age seven.[4,13,16] These women tend to have a weak sense of connectedness with, or concern for, others.[30] They are inclined to be lone parents,[30] or married and employed outside the home with few childcare supports.[2] A lack of personal control seems to be a common factor among women with depression who are socio-economically disadvantaged, lacking in education, and working jobs of low prestige.[30] Data also show that women who have experienced violence (range 25 – 51% in Canada) are much more prone to depression.[27,28]

Strong links have been established between depression and alcoholism and other forms of anxiety disorders,[24] substance abuse, eating disorders, somatization, and personality disorders.[32] Depression has also been associated with more general medical conditions, such as stroke, dementia, diabetes, coronary heart disease, cancer, multiple chemical sensitivities[4,32] and HIV/AIDS.[14,15] Depression has particularly disturbing effects on parental functioning [7,8] and

these effects become more pronounced as the severity of depression worsens.[20,33] The link between depression and child maltreatment is strong.[11,23,33]

The cost of depression is great when calculated in terms of personal satisfaction, family functioning and work performance. Data show that suicide rates are much higher among those who are depressed than the general population; some reports are as high as 70%.[18] The costs of depression in terms of medical care, worker absenteeism and reduced output are estimated at about three billion dollars every year in Canada.[6] Affective diseases (including depression) rank second among the leading causes of hospitalization in Canada.[17] The costs to personal satisfaction and family functioning are incalculable. Depression often leads to family conflict, antisocial behaviour, poor interpersonal relationships, decline in quality of life, alcohol or substance abuse, physical illness and death.[4] The burden in terms of stress, anxiety, lost productivity, lost personal control, and feelings of helplessness is inestimable.

Depression is one of the most treatable mental illnesses.[4] Good results have been reported from a range of help including both informal supports (community groups, self-help groups, health networks) and formal resources (pharmacotherapy, psychotherapy, alternate therapies).[4] Yet, despite the compromising effects of depression on everyday life, many people do not seek help because of the stigma associated with mental illness. This is true of Atlantic Canada.[5] Little is known about how women experience depression in terms of their family, social, and work life. Little is known about the personal coping strategies women use to manage their depression. Even less is known about how, when and in what sequence women decide to use additional informal supports and formal resources to assist in their recovery.

1.3 Methodology

1.3.1 Sample

English speaking women between 20 and 40 years of age who attended Cowie Family Medicine Centre over a 3-month period (to provide a sufficient opportunity to recruit an adequate number of participants) were invited to participate in the study. Cowie Family Medicine Centre is situated in Spryfield on the outskirts of the metro Halifax area. This community is characterized by a relatively low income, transient population living in high-density housing, with insufficient resources.

1.3.2 Design

A qualitative exploratory design was used in this study. Women participated in an interview for about two hours using open-ended questions intended to elicit in-depth stories.

1.3.3 Procedure

The procedure involved several steps:

1. The first step established an Advisory Group of Women who had had a personal diagnosis of depression. The role of this advisory group included evaluating the tools used for the study, providing input on the recruitment and interview processes being used, and to giving input regarding the development of an information package.

2. The advisory group reviewed the interview guide for clarity, relevance, and acceptability. This review resulted in some changes in wording to clarify the focus the interview guide.

3. Recruitment of participants took place at Cowie Family Medicine Centre. To strengthen the Centre's commitment, staff of Cowie Family Medicine Centre and most importantly the nurses, were involved in the recruitment protocol.

4. A video recruitment tape was developed to explain the project and walk the participants through the steps of participation. The tape made the recruitment process less time consuming and ensured that all participants heard a consistent message. The script was developed with input from the advisory group and featured the nurses who worked at Cowie Family Medicine Centre.

1.3.4 Recruitment

1. Any woman between the ages of 20 and 40 years who had an appointment at Cowie Family Medicine Centre between August and December 1998 was a potential participant.

2. A woman was asked by one of the two nurses working at the Centre to view the 13-minute recruitment video in a private room. The nurses gave a brief introduction to the study and if the woman agreed to hear more about the study, the nurse led her to the private and quiet Education Room and turned on the video. The video explained the purpose of the study and provided directions to facilitate participation.

3. One of the nurses on the video introduced the study and explained that it would include two parts: (a) completing a short questionnaire (CES-D Scale[26]) and a demographic form (name and means of contacting the woman) and (b) an interview (within two weeks) for women who were shown to be at risk for depression according to the questionnaire and who agreed to participate. The nurse also explained that if the woman was invited to participate in an interview (at risk for depression and provided contact information), she would be free to refuse or withdraw at any time if she chose, and that the interviewer would be another woman who had experienced depression. The nurse then provided directions for completing the questionnaire and read each question twice very slowly. If the woman viewing the video chose, she filled out the questionnaire and the demographic information form as she watched the tape. The completion of the demographic form was considered initial assent.

   Women were assured on the video that participation was voluntary and they would be free to withdraw from the study at any time without repercussion to their care at Cowie Family Medicine Centre. They were also assured that all names would be kept private and that only the researchers, project coordinator and the interviewer would have access to the information.

To maintain confidentiality, women sealed the questionnaire in an envelope and placed it in a box provided. Only the project coordinator and data analyst had access to the questionnaires.

Women interested in pursuing the study and/or learning more about it provided their name, phone number or other means of contact. They were also invited to provide comments about the video.

4. The Project Coordinator scored the questionnaires. All participants who indicated interest by providing a name and telephone number were contacted and given their score together with an explanation of its meaning. Participants who scored 16 or higher were told the score meant "according to that questionnaire, things didn't seem to be going so well that week". These women were then invited to participate in an interview and receive an information package (including a summary of the results) on depression. Those who scored lower were told "according to the questionnaire, things seemed to be going pretty well for them that week". These women were then asked if they would like to receive an information package (including a summary of the results) once it was completed.

   If the woman agreed to take part in the interview, the coordinator explained how the interview would be conducted and informed the woman of the name of the interviewer who would be calling her to set up an interview time and place of her convenience.

5. The interviewer made contact with the participant and then informed the coordinator of the time and place of the interview.

6. The interviews were conducted according to the open-ended interview guide developed for this study the Difficult Circumstances Scale,[1] designed to ascertain the number of chronic family problems in a person's life, was also completed. The interviews lasted between 1½ to 2 hours and took place between September 1998 and January 1999.

7. Each of the women interviewed was thanked for her participation and sharing her story with a $20.00 honorarium.

1.3.5 Instruments

Demographic Form: This form was used to collect descriptive data regarding participants. Twelve questions asked women about their name, age, address, marital status, educational background, occupation, employment status, financial worries, cultural background, family information, and living arrangements (Appendix A).

CES-D Scale: The Centre for Epidemiologic Studies Depression Scale (CES-D)[26] measures depressive symptomology using a 20-item self-support, single scale that codes the frequency of symptoms over the previous week (Appendix B). The score range is 0-60 and the cut off score for being at risk for depression is 16.

Difficult Life Circumstances Scale: This scale[1] measures the presence of chronic family problems via a 28-item, self-report, single scale that codes the number of difficulties currently being experienced (Appendix C). The score range is 0-28 and the at-risk cut off score is 6.

Semi-structured Interview Guide: This guide, developed for the purpose of this study, is designed to examine women's experiences with (a) depressive symptoms/depression, (b) the effects of depressive symptoms /depression on home, social and work life, (c) personal coping strategies and external resources used to manage the recovery process, and (d) decision-making processes regarding external supports and resources (Appendix D).

1.3.6 Partnerships

Canadian Mental Health Association (CMHA), Nova Scotia Division

Jean Hughes, board member of CMHA, and Doug Crossmann, former Executive Director CMHA, conceptualized the project with consumer input. Gail MacDougal, former executive Director of CMHA, assisted with proposal development. CMHA administered the funds for the project and provided office space and supervision for the project coordinator.

Dalhousie University

A. School of Nursing
Jean Hughes, Associate Professor, School of Nursing, Dalhousie University, was the principal investigator and provided overall supervision to the project. Jean developed the proposal with assistance from Gail MacDougal, and also trained the interviewers and guided the data analysis. A mental health consumer advisory committee (Cheryl Stevens, Carolyn O'Brien, Katherine Campbell, Sharon Campbell) provided input to the recruitment procedure and videotape, the interview guide, interpretation of findings, and the information package.

B. Cowie Family Medicine Centre
Dr. Gerry Broskey, a family physician at Cowie Family Medicine Centre, was a partner in the project. In addition, the two nurses at the centre were key players in the recruitment process. They assisted in the production of the recruitment video and recruited women to the study. As well, they organized a private room for women to watch the recruitment video.

C. Supporter: Captain William Spry Centre
In addition, the Captain William Spry Centre provided a letter of support for the project. The Centre also provided information about mental health services in the Spryfield area and provided a pamphlet to give to the participants. In addition, when the participant's home was not suitable for an interview, the Captain Spry Centre provided space for interviews. The Centre also provided consultation regarding culturally relevant ways to disseminate study results to the community.

1.4 Outcomes and Final Results

1.4.1 Summary

This section summarizes the analysis and interpretation of the qualitative data. The findings relate to: (a) the women's perceptions of **health** as defined by the women during the interview; **feeling blue**, defined as feeling down for less than two weeks – perhaps a day or two as opposed to feeling down for a long period of time; and **depression**, defined as feeling down to the point where it affects your daily functioning; (b) the strategies and resources used to cope with depressive symptoms/depression; and (c) the decision-making processes employed in their selection.

Forty women completed the depression inventory (CES-D scale) and indicated interest in an interview. Twenty-one of these women were eligible for an interview as indicated by their at-risk scores (≥ 16) on the CES-D scale. The first fifteen consenting eligible women were interviewed.

All study participants were of European decent. On average these women were 34 years of age (range = 23 – 40 years), and the majority (67%) did not have a partner. They were moderately literate, with 80% having a high school certificate or more. Two thirds of the women were parents (five families reported no children), with an average of two children per family (range 1 – 3). All children had some experience with caretakers other than their mother.

Household units generally consisted of three people (range = 1 to 6), most of whom held nuclear family ties (two families shared accommodation with friends). Transience was very common among the study population. Nearly half (n = 7) the participants had changed accommodations the month previous to the interview. Over half (n = 8) the women were employed, and the majority of these participants described their occupation (employed or not) as involving skilled labour. Although all women were considered to be of low-income status, only eight (53%) reported that money was a constant worry (one woman did not report).

The first major research finding: Women's perception of health, the 'blues', and depression were distinct. However, some women had difficulty differentiating how they made the transition from feeling the 'blues' for several days, to feeling acutely depressed. One woman reported, "I know when my 'good' is changing to 'medium' [blues], but I don't know when my 'medium' is changing to 'bad' [depression]". At first glance, there seemed to be little difference between how the women described feeling 'blue' versus depressed. However, some subtle differences emerged such as the degree to which the women could function successfully, the severity of their emotions, the length of time the feeling endured. For example, women felt they had a sense of personal control over their lives when healthy, a need to get back on track when blue, and incapacitated and completely withdrawn when depressed. In other words their ability to deal with daily responsibilities in satisfying ways seemed to deteriorate significantly during depression.

The second major finding: Women used different types of strategies, supports and resources to either maintain feelings of well-being, or strengthen their capacity to cope with feeling 'blue' or depressed. These capacity-building strategies, supports, and resources were grouped into three

strategy categories and two support/resource categories: **self-healing/personal care** (e.g., using alternative health remedies, listening to music, eating properly); **interpersonal** (e.g., connecting with others); **cognitive** (e.g., writing in journal, self-help books); **informal supports** (e.g., self-help groups, community groups), and **formal resources** (e.g., family physician, medication, therapist).

The third major finding: Women's interactions at home, on social outings, and at work varied according to where they were on the continuum of emotional well-being ranging from feeling healthy, to feeling 'blue', to feeling depressed. As women moved from wellness to feeling 'blue' or depressed, their interactions became more stressful. More effort was made to mask their feelings of depression at work, and during social occasions, than at home. For some women, work served as a real source of pride and affirmation and they were reluctant to take time off when not feeling up to par. However, when extremely depressed, these women withdrew from the outside world completely.

1.4.2 Capacity Despite Depression

A critical finding is the fact that the strategies and resources used by the women in this study not only varied with the state of health but fit with/were appropriate to the needs and capacities available at the moment. Even when most depressed, women found practical and relevant ways of coping with challenges, and recovering from some very debilitating circumstances.

1.4.3 The Role of Socio-Economic Disadvantage

Despite having to endure socio-economic disadvantage, money was not the major stressor in most women's lives. Only half the women reported money as a constant worry. Given the evidence that financial stress is a major negative influence on well-being, such a finding assists in understanding more about the burden which these women carried in addition their depression. Clearly, other stressors were even more challenging than money for some women.

1.4.4 Profiles

The Healthy Profile

Women were asked to define what health meant to them. For most women, health meant more than just the absence of disease. They defined health as a balance of physical and mental characteristics. The goal during these healthy periods seemed to be to explore and use one's full potential. During healthy periods in their lives the women described their home as peaceful and organized. Socially, the women felt connected to others and enjoyed their company. At work the women felt confident, capable, and thought clearly. When feeling 'really good', informal and formal supports were accessed minimally and friends were accessed spontaneously as desired. Strategies for staying healthy included self-healing and personal care (participating in some form of physical activity, doing things for themselves), and participating in informal support groups. Choices of strategies and resources seemed to be a matter of routine and were performed without rigorous thought.

The Blues Profile

The 'blues' was defined to the participants as: feeling down for less than two weeks – perhaps a day or two as opposed to feeling down for a long period of time. The women added descriptors such as: unsettled, frustrated easily, unmotivated, unhappy, quieter, and "don't want to be around others".

Most women felt they could deal with the blues on their own without much help. The goal of managing the blues seemed to be to get back on track. During 'blue' periods, women continued working even though they may have had increased difficulty thinking clearly, or have taken longer to complete their responsibilities. Nevertheless, they tried to hide their difficulties as work provided affirmation, encouragement, and sense of accomplishment. Socially, women tended to choose their outings purposely according to the people and things that made them feel good. Home life showed more signs of wear. Women reported feeling more irritable, and impatient with family members. Interestingly, in spite of their causing increased frustration, children remained a source of encouragement for women feeling 'blue'. Strategies used to strengthen their capacity to cope during the blues required initiative. Women did not articulate clearly how they selected resources and strategies, but they took deliberate action to feel better and within these strategies they chose specific resources to assist. The selected strategies and resources often were chosen as extra perks to boost women's mood. Cognitive strategies were included much more frequently during the 'blues' than when feeling healthy. Strategies included self-healing/personal care (e.g., alternative health remedies, music, bubble bath), cognitive (e.g., writing in journal, self-help books), and interpersonal techniques (e.g., connecting with special friends).

The Depression Profile

Depression was defined to the participants as "occurring when you feel down to the point where it affects your daily functioning. When these feelings persist for more than two weeks and/or it prevents you from carrying out your daily routine it is depression". The women added descriptors such as: feeling completely withdrawn, sleeping all the time, helpless, and considering suicide.

For the most part, women accessed the formal mental health system only during major depressive episodes when they believed that other strategies were no longer successful. Nine (60%) women reported having a diagnosis of depression yet only six (67%) women reported using formal resources. Women were unable to work during times of depression and, for the most part, they withdrew from social contact. Most found the demands of daily family life exhausting and they withdrew as much as possible (e.g., told their children to make their own meal). They reported feeling angry, guilty, and inadequate. They also felt confused and had difficulty concentrating. The goal of managing depression seemed to be regaining a sense of personal control. Other than the formal system (family physician, mental health professional), strategies used during times of depression were, for the most part, limited to self-healing/personal care (e.g., forcing themselves to take a bath, eat, sit with family for short periods). The one helpful cognitive strategy some women reported was self-coaching. When overwhelmed by feelings of inadequacy, women

identified, and coached themselves through the individual steps of modest concrete actions that provided them with relief or affirmation.

The women had difficulty articulating the processes they went through to select resources and strategies. However, the interviews suggest that women were more likely to try practical strategies that met the basic needs of life (e.g., ensuring that they ate, bathed) and provided relief in the past. They also were more likely to seek out resources (family medical doctor, mental health system) if they believed the service had a good probability of helping. During depression the strategies were even more concrete than those used with the 'blues', and sometimes were basic to survival. They entailed an enormous amount of energy and a target-specific motivator (e.g., to stay alive, I need food; my family cares about me, I will get out of bed and sit with them for 10 minutes).

1.4.5 Future Research

This study provided some insight into the personal experiences of women in terms of how they strengthened their capacity to manage health and many levels of depression. Clearly, one of the limitations of the study, although not intended, was that its focus was limited to women of European decent. While all women between 20 and 40 years were eligible, only women of European decent indicated an interest in the study during the set timeframe. Given that the stigma of mental illness and access to mental health services vary with culture, it is recommended that future research explore ways for recruiting women of diverse cultures and documenting their experiences with depression.

1.4.6 Recommendations

The women identified a number of coping strategies and resources/supports used during the coping and recovery process that served to strengthen their mental health capacity. They also made recommendations concerning improvements to accessibility to informal supports (e.g., peers) and formal resources (e.g., counselling) for women coping with the blues and/or depression.

Accessibility. Women reported that the formal health system is not user friendly, relevant, affordable, or seamless for low-income women with depression. Given the trajectory of depression (episodic, irregular), rather than having to endure long waiting times and incur high travel/child care costs, women argued that services need to be timely, offered in a geographic location that minimizes transportation and provides child care services. One woman said,

> The service has to be there without the cost. It has to be. It has to be taken into consideration. To me, one-on-one, face-to-face contact is a lot more. It's more productive for me than doing it over the phone. I mean I have a great phone network support system but being able to do that face-to-face means much more to me. And child care and transportation problems, again that has to be rectified because you don't know when these blues or depressions or any of this is going to hit you. It's not a planned event. It's not ... There is no timetable to it. It just

> comes. And that is not always workable for child care, transportation or face-to-face. And I think that is key to any healing and progressing.

Peer Support. Women agreed that formal services often were not psychologically accessible and they often felt misunderstood. They recommended that peer counsellors be made available to provide experiential knowledge, validation, and encouragement. One woman said,

> I think that having the services available and having them run by people who have actually experienced all of this... it doesn't have to be somebody that is trained education-wise... being told out of a textbook, it's totally different... In my mind, I wonder do they ever really know what I am going through?

1.4.7 Schedule of Activities Carried Out in Relation to Activities Planned, including an Explanation of Modifications

All of the objectives for the project were reached. We (a) recorded the stories of women who were at risk for/experience depression; (b) examined the effects of setting (home, work, social) on the experience of depressive symptoms/depression; (c) described the personal coping strategies and resources (informal and formal supports) women used during the coping and recovery process to strengthen their mental capacity; and (d) identified the process women used in making decisions about accessing informal supports and formal resources. The responses to our final objective were often not well defined. Instead we were able to capture more easily the types of strategies and resources used. It may be that women were not always aware (as in the case of depression) of the processes they used to problem-solve or make decisions.

The project was completed without any significant difficulty that required major change to the protocol. However, recruitment time was longer than expected. Factors affecting the length of time for recruitment included: the extended production time required for the recruitment video, and the reduced time the nurses had available for recruitment due to their demanding work schedule.

2.0 Dissemination Plan and Knowledge Sharing

The project outcomes will be disseminated in a variety of ways to a number of different audiences.

1. An information package (diary called "Women's Wisdom) has been developed for women interested in the coping and recovery processes (strategies, resources) of depression. These packages are being prepared with the assistance of a graphic artist having considerable experience working with sociodemographically-disadvantaged women. The package includes information and resources, and is interactive and packaged in ways suggested by the findings, and direct input from the mental health consumer advisory group. The packages will be field tested by willing study participants, other low income women of varying ages who are experiencing varying levels of health or depression (e.g., self-help groups, self-disclosed

volunteers). Copies of the final prototype will be distributed to all of the women who participated in the study. In addition, it is hoped that funding will be secured for a wider distribution of this package.

2. We will work with the Captain Spry Centre to identify community groups and relevant and accessible ways to disseminate the study findings. Women on the mental health consumer advisory group will be invited to help design and participate in these forums.

3. We will submit study reports to the Community Health Boards in Spryfield and the Central Regional Health Board and, given the small sample size, request an opportunity to discuss the service and policy implications of the findings. We will also circulate copies of the study report to the other Regional Health Boards.

4. We presented study results at the Canadian Mental Health Association's national conference in Vancouver, August 1999 and at the International Conference on Women's Health in Delhi, India in March 2000.

5. Articles will be submitted for publication to journals (e.g., *Canadian Journal of Community Mental Health*) and lay magazines (e.g., *Chatelaine*).

6. We published an article for the Canadian Mental Health Association, Nova Scotia Division (CMHA) newsletter. This newsletter is distributed to approximately 1,200 individuals and organizations (formal and informal) across Nova Scotia.

3.0 Summary of Expected Outcomes and Impact of the Project with Respect to MCEWH Mandates and Programs of Research

The Maritime Centre of Excellence for Women's Health strives to:

- listen and hear the voices of women not typically heard in health research or health systems;
- explore strategies that build upon the needs identified by women and address the factors that influence health; and
- influence public policy through research and action.

"The Stories of Women Living With Depression**:** Their Coping Strategies and Resources" study addressed all of the Centre's goals. The outcomes of the study reflect the voices of women living in a low-income community that has few resources. The study explores the strategies these women use to work toward health when experiencing depression. The outcomes of the study send a clear message to policy makers and service planners/providers that it is necessary to provide mental health services that are accessible (psychologically, financially, geographically), and that integrate formal and informal supports and resources. In particular, greater use of peer consumers is highly recommended

3.1 Impact on Policy and/or Programs

The results of "The Stories of Women Living With Depression: Their Coping Strategies and Resources" study can make a contribution towards the development of policies and/or programs aimed at improving the health of low-income women who have depression. The results should be used to develop educational programs for mental health consumers, family members of women living with depression, and the general public. These programs should pay particular attention to the transition period from feeling the 'blues' to being depressed, and on ways to match need with relevant strategies and resources for coping with depression. The findings should also contribute to the education of health professionals regarding the place of formal treatment in the coping and recovery processes and on ways that formal treatment can be integrated with, or augment other vital supports (e.g., peers). Workplaces can benefit from the results of the project as well. The results indicate the importance of educating workplaces on mental health friendly policies that decrease stigma, increase acceptance of an employee with depression and allow for flexibility while living with an often recurring and irregular mental illness and working towards health. There is a strong message to be presented to policy makers and mental health services planners about the need to provide mental health services that integrate formal and informal supports and resources.

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Appendix A: Demographic Data Form

Name:

Age:

Marital Status:
- married
- single
- cohabiting
- divorced
- widowed

Last grade completed:

Number of Children:

Child care arrangements:

Number of people living in the home:

Relationship of people living in the home:
- # of people living in the home
- nuclear family
- extended family
- boyfriend
- boarder
- other

Have you moved in the last 12 months?

Occupation:

Employment Status:

Financial: Do you have sufficient money to meet the needs of daily life or is it a constant worry?
How would you describe your cultural background?

Appendix B: CES-D Scale

Instructions for questions: Below is a list of the ways you might have felt or behaved recently. Please tell me how often you have felt this way during the past week, using the alternatives below.

1 - Rarely or None of the time (less than 1 day)
2 - Some or a little of the time (1-2 days)
3 - Occasionally or a moderate amount of the time (3-4 days)
4 - Most or all of the time (5-7 days)

___1. I was bothered by things that don't usually bother me.
___2. I did not feel like eating, my appetite was poor.
___3. I felt that I could not shake of the blues even with help from my family or friends.
___4. I felt that I was just as good as other people.
___5. I had trouble keeping my mind on what I was doing.
___6. I felt depressed.
___7. I felt that everything I did was an effort.
___8. I felt hopeful about the future.
___9. I thought my life had been a failure.
___10. I felt fearful.
___11. My sleep was restless.
___12. I was happy.
___13. I talked less than usual.
___14. I felt lonely.
___15. People were unfriendly.
___16. I enjoyed life.
___17. I had crying spells.
___18. I felt sad.
___19. I felt that people dislike me.
___20. I could not get going.

Please complete the following if you would like to participate in part II of the study or if you would like more information.

Name: _____
Address: _____
_____
Phone #: _____
Comments: _____
_____

Appendix C: Difficult Life Circumstances Form

Name_____ Marital Status_____ Age_____ Race_____ Sex_____
Education_____ Occupation_____ # of children____ under 5 yrs _____ 5-19 yrs

Below is a list of problems. You must decide if a particular one is a problem for you. Check which ones apply. If any of these questions make you uncomfortable you don't have to answer. We can help you the most by knowing the difficult circumstances you face in your life. [Participants were asked to check a box marked 'Yes' or 'No']

1. Are you having regular arguments or conflicts with your present partner /steady boy/girlfriend?
2. Are you having some sort of problem with any one of your former spouses/partners?
3. Is your partner in jail?
4. Is your partner away from the home more than half of the time because of a job or other reason?
5. Do you have long-term debts other than a house mortgage (2 years or more)?
6. Do you have problems with your credit rating? Do you get hassled pretty often by bill collectors or collection agencies?
7. Have you been looking for a job and have not been able to find one? (Score as a No if mother, is employed, or not looking)
8. Does your work interfere with your family life? (No if not working or no family)
9. Does your partner's work interfere with your family life? (No if no partner)
10. Do you have trouble with your landlord? (No if own home)
11. Do you have trouble finding a place to live that is suitable and you can afford?
12. Do you feel that you do not have enough privacy?
13. Do you have people living with you ...relatives or friends - that you wish weren't there?
14. Do you have neighbours who are really unfriendly or giving you problems?
15. Do you or someone in your household have a long-term illness?
16. Have you had frequent minor illnesses in the past year?
17. Do you have a problem with alcohol or drugs (prescription or street)
18. Does your partner have a problem with alcohol or drugs?
19. Does someone in your household other than you or your partner have a problem with alcohol or drugs?
20. Have you been the victim of a crime in the past year?
21. Has your current partner ever physically abused you? (No if no partner)
22. Has your current partner ever verbally or emotionally abused you (put downs, or saying things that make you feel really bad or worthless)?
23. Is someone other than your present partner presently abusing you sexually, physically or emotionally?
24. Have you been hospitalized in the past year for any reason - accident or illness?
25. Are you without a phone at your present home or apartment?
26. Is one of your children being abused sexually, emotionally, or physically (by anyone)?
27. Is one of your children experiencing learning problems or other school problems that require you to consult with the teacher or other school officials?
28. Has one of your children been having serious emotional or behavioural problems at home (e.g., repeated nightmares, repeated tantrums, repeated major aggressive outbursts, etc.)?

Appendix D: Interview Guide

HEALTH

1. People think of health in different ways. What does health mean to you?

2. Can you tell me what you feel like when times are good, when you feel healthy?

3. How would you describe your life when things are going well?
   Home:
   Social:
   Work (if applicable): Remember this includes volunteer work.

   The interviewer will explore with the respondents:
   - Areas related to home life, relationships with family members, friends; and workplace colleagues (if applicable)
   - Ability to pursue their interests and responsibilities at home, work, community/social, level of enjoyment, satisfaction in the above areas

4. How do you know when you are feeling good? What tells you things are okay?

5. What do you do to stay well/feeling good?

6. Who do you call on to help you stay well?/ Who do you rely on to keep you feeling good?
   - Inquire about informal supports (family, friends, community groups), and formal resources (family doctors, mental health system)
   - When do you contact these supports and resources and what do you hope to get from them?
   - Do the supports and resources usually meet your expectations? If so how, if not why not?
   Ask for an example of when their expectations were met and when their expectations were not met.

7. Using your definition of health, on a scale of 1 –10, 1 being low and 10 being high how healthy would you say you are toady?

BLUES

In the next set of questions, I will be asking you about feeling the ‘blues’ or ‘down in the dumps’. For the purpose of this interview, we will define the blues and down in the dumps in the following way:

The blues/down in the dumps: feeling down for less than two weeks – perhaps a day or two as opposed to feeling down for a long period of time. You can continue most aspects of your daily routine.

8. Can you tell me what you feel like when you are feeling ‘blue’, or ‘down in the dumps’?

9. How would you describe your life when you are feeling ‘blue’ or ‘down in the dumps’?
   Home:
   Social:
   Work (if Applicable): Remember this includes volunteer work

   The interviewer will explore with the respondents: Areas related to home relationships with family members, friends; and workplace colleagues (if applicable) ability to pursue their interests and responsibilities at home, work community/social, level of enjoyment, satisfaction in the above areas.

10. How do you know when things are getting bad? What tells you things are getting bad? (home, social/relationships, work)

11. What do you do to cope with ‘the blues’?
    What do you do to change how these feelings affect your life?
    How do you manage to get through a bad day?

12. If these feelings continue for more than 2 days can you tell me how you manage to get through that ‘blue’ period?

13 When you were feeling blue, did you seek support from other people? If yes, who did you call on? If no, did anything stand in the way of your seeking support from others? (e.g., violence, family conflict/abuse, finances, lack of resources, transportation, other people’s attitude) Inquire about informal supports (family, friends, community groups), and formal resources (family doctors, mental health system)

    When do you contact these supports and resources?

    How do you decide when to go?

    What do hope to gain from them?

    Do they meet your expectations? If so how, if not why not?

    (Ask for an example of informal and formal)

14. Are there supports or services that would have been helpful to you but were not available when needed? If so, explain.

DEPRESSION

The next set of questions asks about clinical depression.

Depression occurs when you feel down to the point where it affects your daily functioning. When these feelings persist for more than two weeks and/or it prevents you from carrying out your daily routine it is depression.

15. The questionnaire you completed in part I of this study at the clinic showed that you had quite a few feelings of depression that week. On a scale of 1-10, 1 being low and 10 being high, how would you compare your feelings today with that day in the clinic?

16. Can you tell me what you felt/feel like when you were/are feeling depressed?

17. How would you describe your life when you were/are feeling depressed?
    Home:
    Social:
    Work (if applicable) Remember this includes volunteer work)

    The interviewer will explore with the respondents:
    - Areas related to home life, relationships with family members, friends; and workplace colleagues (if applicable)
    - Ability to pursue their interests and responsibilities at home, work, community level of enjoyment, satisfaction in the above areas

18. How did/do you know when things were/are getting bad? What told/tells you things were/are getting bad?

19. What did/do you do to cope with depression?
    What did/do you do to change how these feelings affect you?
    How did/do you manage to get through a bad day?
    How long did your depression last?

20. A. Tell me how you managed to recover from that depressed period?
    B. What did/do you do for yourself to work towards wellness?

21. When you had/have feeling depression, did/do you seek support from others? If yes, who did/do you call on during this time? If no, did anything stand in the way of your seeking support from others? (e.g. violence, family conflict, finances, lack of resources, transportation)

    Inquire about informal supports (family, friends, community groups), and formal resources (family, doctors, mental health system)

    When do you contact these supports and resources?

    How do you decide when to seek support?

What do hope to gain from them?

Do they meet you expectations? If so how, if not why not?

(Ask for an example of informal and formal supports)

22. Have you ever been diagnosed with clinical depression? When?

COPING STRATEGIES

23. Do you increase or decrease use of substances (e.g. food, drugs (prescription/street), alcohol, tobacco, caffeine) to help you cope with feeling: a) blue? b) depressed?

24. On a scale of 1-10, 1 being low and 10 being high, how would you describe your level of concern about the way you feel when a) blue? b) depressed? That is, are you concerned it won't get any better or may even get worse.

25. How well are you able to carry on with your interests/responsibilities when a) blue? b) depressed?

26. Have others told you that you should get help? If so, what kind?
What influence, if any, did this have on your decision to seek assistance?

27. Are there supports or services that would have been useful to you but were not available when you wanted them? If so, explain

28. If you could talk to those who try to offer help, (both formal and informal supports) what would you like them to know that could help women like you with a) the blues? b) depression?

29. Is there anything else you would like to tell me?

Appendix E: Research Fact Sheet

The Stories Of Women Living With Depression

Principal Investigator: Jean Hughes

Co-investigators: Gail McDougall, Gerry Brosky

Contact Name: Cathy McCormack
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Research Finding #1:
Women's perception of health, the "blues", and depression were distinct. However, some women had difficulty differentiating how they made the transition from the "blues" to depression.

Research Finding #2:
Women used different types of strategies to either maintain feelings of well-being, or strengthen their capacity to cope with feeling "blue" or depressed. These capacity-building strategies were grouped into five categories: **self healing/personal care** (e.g., alternative health remedies, listening to music, eating properly); **interpersonal** (connecting with others - friends, family, coworkers); **informal supports** (e.g., self-help groups, community groups); **cognitive** (e.g., Writing in a journal, self-help books); and **formal health system** (family doctor, medication, therapist)

Research Finding #3
Women's interactions at home, on social outings, and at work varied according to where they were on the continuum of emotional health ranging from feeling healthy, to feeling "blue" to feeling depressed.

Recommendation for Future Research:
Explore and compare women's perspectives on well-being used to manage and recover from depression with other marginalized groups (e.g., Indigenous black, First Nations, New Canadians)

Appendix F: Policy Fact Sheet

The Stories Of Women Living With Depression

Investigators: Jean Hughes

Co-investigators: Gail McDougall, Gerry Brosky

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Major Finding #1: Women's perception of health, the 'blues', and depression were distinct. However, some women had difficulty differentiating how they made the transition from the 'blues' to depression.	**Program Implications with Major Finding #1:** A. Educate consumers, family, and general public on the transition signs to depression; strategies specific to the transition period; and resources to use to prevent and/or minimize the transitional marker
Major Finding #2: Women used different types of strategies to either maintain feelings of well-being, or strengthen their capacity to cope with feeling 'blue' or depressed. These capacity-building strategies were grouped into five categories: **self healing/personal care** (e.g., alternative health remedies, listening to music, eating properly); **interpersonal** (connecting with others - friends, family, coworkers); **informal supports** (e.g., self-help groups, community groups); **cognitive** (e.g., writing in a journal, self-help books); **formal health system** (family doctor, medication, therapist)	**Policy/Program Implications with Major Finding #2:** A. Educate community, families, consumers, and providers regarding how to match need with appropriate strategies and resources for coping with depression. B. Educate health professionals regarding the place of formal treatment in coping and recovery processes and about how formal treatment can be integrated with other vital supports. Formal treatment is only one type in a range of supports. C. Advocate to policy makers and mental health services planners about the need to provide mental health services that integrate formal and informal supports and resources.
Major Finding #3 Women's interactions at home, on social outings, and at work varied according to where they were on the continuum of emotional health ranging from feeling healthy, to feeling 'blue' to feeling depressed.	**Policy/Program Implications with Major Finding #3** A. Educate workplaces to promote mental health friendly policies that decrease stigma, increase acceptance of an employee with depression and allow for flexibility while working towards health.